Issues Concerning Hospital Supplemental Payment Programs under the Office of the Secretary of Family and Social Services

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Health Finance Commission

Indiana Legislative Services Agency

Legislative Evaluation and Oversight

The Office of Fiscal and Management Analysis is a division within the Legislative Services Agency that performs fiscal, budgetary, and management analysis. Within this office, teams of program analysts evaluate state agency programs and activities as set forth in IC 2-5-21.

The goal of Legislative Evaluation and Oversight is to improve the legislative decision-making process and, ultimately, state government operations by providing information about the performance of state agencies and programs through evaluation.

The evaluation teams prepare reports for the Legislative Council in accordance with IC 2-5-21. The published reports describe state programs, analyze management problems, evaluate outcomes, and include other items as directed by the Legislative Evaluation and Oversight Policy Subcommittee of the Legislative Council. The report is used by an evaluation committee to determine the need for legislative action.

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Preface

Each year, the Legislative Services Agency prepares reports for the Legislative Council in accordance with IC 2-5-21. This report concerns the Disproportionate Share Hospital Care Payment Program; the Hospital Care for the Indigent Program; and the Upper Payment Level Program as directed by HEA 1194 - 2009. All three programs are administered by the Office of the Secretary of Family and Social Services and the Office of Medicaid Policy and Planning. It has been prepared for use by the Health Finance Commission.

This report contains an overview of each program including a look at the state and federal history of each program, program requirements, description of how the program works, and an evaluation of Indiana hospital data.

We gratefully acknowledge all those who assisted in preparation of this report. The staff of the Family and Social Services agency, its contractors, and the Indiana State Department of Health were helpful in their responses to our requests for information. We also acknowledge all those who responded to our questions concerning these programs or who assisted in the preparation of this report.

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Executive Summary

Legislation passed during the 2009 legislative session required review of three Indiana supplemental payment programs for the hospitals that make up the state's safety net. The three programs reviewed include the Hospital Care for the Indigent (HCI), the Upper Payment Level (UPL), and Disproportionate Share Hospital (DSH) programs. This report examines the payments and revenue sources to determine how the State Medicaid Plan and federal approvals affect the implementation of statute, looks at the impact of the Healthy Indiana Plan on federal funds for supplemental payments, and then employs the methods used in a national analysis to examine the characteristics of Indiana safety net hospitals.

The Programs

The HCI program is the oldest of these programs and began as a county-funded, county-operated program. The state assumed administrative responsibilities for the program in 1987. In 1995, the program began funding Medicaid add-on payments to match additional federal funding, rather than provide reimbursement for indigent care the program had originally funded. The state assumed the HCI property tax levy in 2009, which ended the HCI funding source, and the distinct payment program made no payments in 2008 or 2009.

The UPL and DSH programs are both connected with the federally sponsored, state-administered Medicaid program. The programs are authorized in state statute and operated according to the State Medicaid Plan which is approved by the federal Centers for Medicare and Medicaid Services (CMS) and administered by the Office of Medicaid Policy and Planning within the Office of the Secretary of Family and Social Services.

Under federal Medicaid law, states are allowed to set their own Medicaid payment rates within certain parameters. The federal law allows states to pay up to Medicare rates, which are set by the federal government. States began paying a supplemental amount to hospitals based on the gap between the rates set by the state Medicaid plan and the Medicare upper payment limit (UPL). The CMS approves the UPL payments when it approves a state Medicaid plan, and certain federal regulations apply to limit this payment program. However, the program is not specifically required in federal law. UPL amounts are pooled by hospital type, but may be paid out within the pool as determined by the state. There is no specific hospital limit for UPL payments.

The DSH program began as a specific federal program that encouraged states to make additional payments to hospitals that serve a disproportionate share of low-income patients. Limitations to the program were applied at the federal level when states began using circuitous funding schemes to draw down additional federal funds and using the funds as a substitute for general appropriations. The limitations include an allotment to each state and hospital-specific limits on the amount each hospital may receive. UPL payments count toward the DSH hospital-specific limit.

The Indiana Medicaid State Plan

The Indiana Medicaid State Plan is a voluminous document with certain sections concerning HCI, UPL, and DSH. The state legislature may direct the OMPP to submit amendments to the state plan to CMS, or the state plan may be shaped by negotiations with CMS. In review of a state plan, CMS looks to support of the document's policies in the state statute. However, the state statute and the state plan do not always coincide. Amendments to the Indiana State Plan were not finalized, and therefore changes to supplemental payments made in 2007 legislation are not reflected in the State Plan. Funding source elimination in 2008 legislation is also not reflected in the State Plan.

How Medicaid Supplemental Payments Work

There are four parts to the Medicaid supplemental payment programs. First, there is nonfederal revenue, including state general funds, intergovernmental transfers, certified public expenditures, and provider taxes. Next, there are federal matching funds, which represent about 64% of funding overall for Indiana. The funds from these sources are paid into the Medicaid-current obligations account or the Medicaid Indigent Care Trust Fund. From these funds, the resources are paid to hospitals through the payment programs.

In the past three years, the revenue sources for the UPL and DSH programs have consolidated and include the state General Fund, appropriations to state agencies, and intergovernmental transfers from nonstate, government-operated hospitals, Indiana University, and the Health and Hospital Corporation of Marion County. When compared with revenue sources in 2000, certain revenue sources have been discontinued, including HCI property taxes, community mental health/county-funded certified public expenditures, and the Health and Hospital Corporation's and nonstate, government-operated hospitals' intergovernmental transfers on behalf of other hospitals.

A review of the number of hospitals receiving payments from the supplemental payment programs has decreased between 2000 and 2008-2009, and between 2007 and 2008-2009. This is primarily due to non-DSH-eligible hospitals no longer receiving HCI-funded reimbursement for indigent care. The amount of payments received have changed as well with changes in the order that the supplemental payments are made. In the past two years certain hospitals have received a percentage of the full hospital-specific limit. Additionally, the Healthy Indiana Plan (HIP), enacted in 2007, has limited the amount of funding available to the DSH program with a HIP demonstration waiver, but has provided additional funding to a broader range of hospitals. In this way, the HIP may reach hospitals that once received HCI reimbursements, but no longer receive supplemental payments.

Characteristics of Indiana Safety Net Hospitals

A review of hospitals was undertaken by ranking acute-care and short-term-stay hospitals based on the amount of uncompensated care provided. This method was used in a nationwide hospital study completed in 1997. Many of the findings of the Indiana review coincided with the 1997 study, including that the Indiana safety net is made up of rural hospitals as well as urban hospitals and that safety net hospitals have fewer beds than average. The safety net hospitals tend to depend more on patient revenues, and they are owned by local governments and nonprofit private organizations. It was also found that more of the revenue of safety net hospitals comes from Medicare and Medicaid than from other payers such as patients and insurers. With certain exceptions, most of the payments from the Medicaid supplemental programs go to the hospitals that provide the most uncompensated care, but the measure of uncompensated care in the study and that is used in supplemental programs varies.

Conclusion

A review of Indiana's three supplemental payment programs finds that the programs provide additional funding for safety net hospitals - hospitals that provide services for low-income and indigent residents. The HCI program is no longer functioning as a separate program. As a result of the discontinuation of the property tax that funded HCI payments, private hospitals and nonstate, government-owned hospitals that are not DSH-eligible are not receiving as much in direct Medicaid supplemental payments. However, these hospitals are being compensated, somewhat, through additional insurance payments through the HIP.

Introduction

Legislation passed during the 2009 legislative session required the Legislative Evaluation and Oversight Policy Subcommittee (LEOPS) of the Legislative Council to evaluate hospital supplemental payment programs under the Office of the Secretary of Family and Social Services (FSSA). The programs to be evaluated include:

> **The Hospital Care for the Indigent Program (HCI).** HCI was originally a county program that became a county-funded, state-administered program to provide additional funding for hospitals that provide care for indigent patients. Beginning in 2009, the state has eliminated the local funding of HCI, and the program ceased to function as a separate supplemental payment program for hospitals.
>
> **The Upper Payment Level Program (UPL).** The UPL program provides an additional payment to hospitals that serve Medicaid patients under certain federally imposed limits, but is not a federally required program.
>
> **The Disproportionate Share Hospital Care Payment Program (DSH).** DSH is a state and federal partnership program to provide additional payments to hospitals that serve as a safety net. Under federal requirements, this program has both state allocation limits and individual hospital caps.

The oldest of the three programs is HCI, and UPL, the most recent, was enacted into state statute in 1998. Jointly, HCI, UPL, and DSH provide payments to hospitals that are in addition to the basic Medicaid funding for hospitals. Within the federal Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, is Section 1923, which requires states, through the State Medicaid Plan, to provide an appropriate increase in inpatient rates for hospitals that provide a disproportionate share of medical care for low-income individuals with special needs. It is the state statute and resulting rules contained in the State Medicaid Plan and the federal limitations of the Medicaid program that shape and enable these supplemental payment programs.

Medicaid is jointly administered between the federal and state governments. One hallmark of the Medicaid program is the sharing of expenses between the states and the federal government, where the states determine, within federally established parameters, the amount of reimbursement they will provide for patient services. The federal matching share is determined by a state's income relative to all states' incomes, and in Indiana, on average, is typically about 64% of program funding. Since hospitals that serve a disproportionate share of low-income[1] and indigent[2] individuals may not receive sufficient funds to operate, supplemental payment programs evolved.

The federal supplemental payment programs operate in the same way as Medicaid, with states setting payment policy concerning payments within broader federal guidelines, and a federal match providing about two-thirds of the program funding. For these supplemental payment programs, certain federal limits have been enacted in federal statute and rules. Also, all payment methodologies are written into the State Medicaid

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[1]People who may qualify for Medicaid and may be able to pay some portion of health service charges.

[2]People without the means to pay for medical services and who, mostly, do not qualify for Medicaid.

Plan, which must be approved by the federal oversight agency, the Centers for Medicare and Medicaid Services (CMS). State statute sets the state's policy, but the federal oversight shapes the actual way in which the program works. In this review, a disconnect between state statute and the State Medicaid Plan is discussed.

This paper also reviews the ways in which the programs have made supplemental payments in recent years. Also, the history of the funding and payments for the Medicaid supplemental payment programs is reviewed. A federal Medicaid waiver for a demonstration project, the Healthy Indiana Plan, is also discussed for its impact on DSH funds and hospitals providing services to low-income and indigent individuals. Finally, financial and other information from acute care and critical access hospitals are used to analyze the characteristics of the hospitals that form the safety net in Indiana.

Evaluation Technique

The history of programs developed for this report came from a variety of places, including review of state statutes, interviews with people of interest, and interim committee testimony. A literature review provided a method for evaluating safety net hospitals, which was undertaken with data provided both by Myers and Stauffer, a contractor for the FSSA, and from website reports from the Indiana State Department of Health. Myers and Stauffer and the Office of Medicaid Policy and Planning (OMPP) within the FSSA also provided information concerning payments from the Medicaid supplemental payment programs.

Terminology

Throughout the paper, there are certain terms that have specific meanings. Some of the definitions that will promote understanding of the descriptions of the programs are provided here.

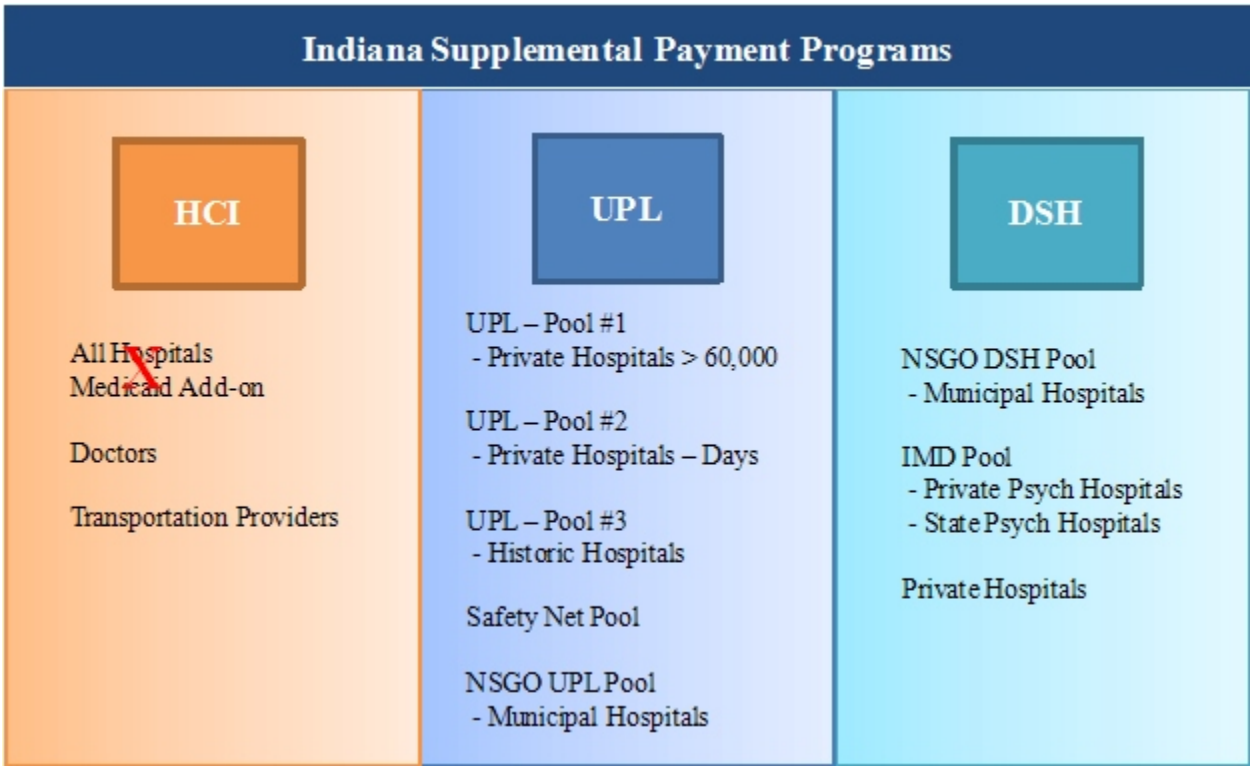
Charges, Revenue, and Costs. The full amount that a hospital requests for its services are the charges. Gross charges may be reduced by contractual agreement or discounted, resulting in the net charges. The amount that the hospital receives, regardless of source, is the revenue. And the amount paid for staff and equipment to provide a service is the hospital's cost of service.

Upper Payment Limit and Medicaid Shortfall. For the purposes of this paper, *upper payment limit* will equal the difference between services valued under Medicare payment principles and Medicaid receipts for services, while *Medicaid shortfall* will mean the difference between a hospital's cost of services provided to Medicaid patients and the Medicaid payments received. This usage coincides with federal terminology, but conflicts with state statute which in IC 12-15-15-1.1(f) describes the Medicaid shortfall as synonymous with the upper payment limit.

Medicaid Supplemental Payments at Work

This section describes how payments are made from each supplemental payment program, but first describes the program itself and some of the eligibility requirements and payment limits. Then, the payment methodology, including the pooling of hospitals into groups for payment (as seen in Exhibit 1), will be discussed. Finally, payments from each program will be compared over the years to show how funding changes and payment methodology has changed what each pool of hospitals receives.

Exhibit 1. Indiana's Supplemental Payment Programs.



Each of Indiana's programs provides funding to distinct groupings of hospitals. However, in some cases, these programs overlap, and funding from one program may limit or prohibit payments from another program.

[State and federal legislative history is described in Appendix A.]

Hospital Care for the Indigent (HCI) Program

The Hospital Care for the Indigent program was historically funded through local property tax levies and authorized in statute to pay for emergency care for indigent county residents and indigent visitors who needed emergency care while visiting the county. Over time, the HCI funds were used to leverage federal Medicaid funding by paying for certain Medicaid services or by making Medicaid add-on payments. The only

eligibility requirements for a hospital to receive payments through the HCI program were that the hospital provided uncompensated care to uninsured or indigent individuals. Consequently, most if not all hospitals were eligible to receive HCI payments.

In 1995, the HCI funds began to be used as the state match for federal funds by providing to hospitals an add-on payment to regular Medicaid program reimbursement. Funds in excess of those needed for add-on payments were used as the nonfederal match for UPL supplemental payments.

In 2008 legislation, the state assumed responsibility for several local property tax levies for welfare funds, including the levy for the HCI fund. Beginning in 2009, the state provides approximately the same level of support for supplemental Medicaid payments through the use of general revenues. For all practical purposes, HCI-funded payments are no longer used for the direct funding of indigent hospital care or UPL payments. However, by statute approximately $3 M in state funds continue to be used for the nonfederal match to make payments to physicians and transportation providers.

An HCI payment methodology still exists in state statute. However, no HCI payments to hospitals or HCI-funded Medicaid add-on payments were made in 2008 or 2009.

Upper Payment Limit (UPL) Program

The Upper Payment Limit supplemental payment program is not a separately enacted program at the federal level. Instead, UPL payments are a feature of the regular Medicaid program and represent an additional payment to a hospital or nursing home facility that was already compensated for providing Medicaid services through the existing claims-based reimbursement system. There is no federal requirement for states to make these particular supplemental payments, nor are there federally mandated methods for calculating UPL payments. However, the methods adopted by the state for formulating UPL payments must be approved by the CMS in the State Medicaid Plan.

Within the Medicaid program, there are general guidelines for what states can reimburse, including a ceiling or upper limit. Under federal rules, the reimbursement "may not exceed the amount that would have been paid for those services under Medicare payment principles. [3] States pay hospitals under Medicaid reimbursement methodologies established in the State Plan, and then estimate how much more the hospitals would have been paid for the services under Medicare principles. The difference between the payments and the estimate is the amount that is available for additional reimbursement and referred to as the upper payment limit.

UPL payments were historically reported with other hospital payments for purposes of claiming federal match. However, effective October 2009, the federal reporting form was modified to require separate reporting of UPL payments.

Eligibility Determination for UPL

Since a UPL payment is an add-on payment to the amounts paid for Medicaid services, any hospital providing Medicaid services would qualify within federal requirements. Although state statute and the State

[3] 42 CFR 447.272.

Medicaid Plan provide the potential for all hospitals to be eligible for UPL payments, the current payment methodology results in only DSH-eligible private hospitals receiving private UPL supplemental payments. [Prior to 2004, non-DSH hospitals received only HCI payments. Beginning in 2004, private non-DSH hospitals also received UPL payments. However, as will be described in more detail later, since 2008, no UPL payments have been made to private hospitals that were not also eligible for DSH.]

UPL Payment Caps

UPL supplemental payments are not subject to either individual hospital-specific caps or a single statewide limitation. Rather, the payment limitations are based on the aggregated UPL of all hospitals for each of the following mutually exclusive categories:

(1) Inpatient services in state-owned or -operated facilities.
(2) Outpatient services in state-owned or -operated facilities.
(3) Inpatient services in publicly owned or operated facilities (not state government).
(4) Outpatient services in publicly owned or operated facilities (not state government).
(5) Inpatient services in privately owned or operated facilities.
(6) Outpatient services in private owned or operated facilities.

The upper payment limit is aggregated over all hospitals in each category, regardless of subsequent determination of DSH eligibility or payment under the UPL program. Because of this and because there is no hospital-specific limit for UPL payments, an individual hospital is allowed to receive more in supplemental payments than the hospital's own upper payment limit amount as long as the payments to the hospital do not exceed the hospital's charges for inpatient Medicaid services and the total payments for all of the hospitals in the category do not exceed the aggregate upper payment limit for that category.

The six categories listed above are used for determining aggregate hospital payment limitations and do not describe the categories or payment pools to which UPL and DSH payments are directed. The payment pools are described later.

UPL payments are considered non-DSH supplemental payments.

Disproportionate Share Hospital (DSH) Program

Safety net hospitals serve a disproportionate share of people who are indigent or are Medicaid patients. Research has shown that safety net hospitals also train the majority of the country's graduate medical students. The Disproportionate Share Hospital Payment Program provides additional payments to hospitals that provide a safety net for indigent and low-income individuals. The payments are in addition to payments received by the hospitals from Medicaid claims-based reimbursement (including any UPL payments) or any other public or private payment on behalf of indigents.

Disproportionate Share Hospital adjustments were established by Congress in 1981 when states were released from the requirement of reimbursing providers of inpatient hospital services on the basis of Medicare payment principles. In return for the increased flexibility in determining their Medicaid reimbursement levels and the potential for severely reduced reimbursement, states were required to provide assurances that payment rates were "reasonable and adequate" and "take into account the situation of

hospitals which serve a disproportionate number of low-income patients with special needs" by increasing payment rates for those hospitals. Because Medicaid payment levels tend to be lower than Medicare, DSH payment adjustments were mandated as a method of protecting hospitals serving disproportionately large numbers of low-income and uninsured patients.

DSH Eligibility Determination

There is no single definition of a safety net hospital. Originally, the determination was left to the states. Under federal program requirements, as of 1987, there are two tests to determine if a hospital is eligible for DSH payments.

- A Low-Income Utilization Rate (LIUR) hospital has low-income utilization of at least 25%. This is determined by analysis of the hospital's revenues and charges.

- A Medicaid Inpatient Utilization Rate (MIUR) hospital has a Medicaid utilization rate more than one standard deviation above the average Medicaid utilization rate, statewide.

Eligibility determination begins with cost information supplied by the hospitals to the OMPP and the OMPP's consultants. One year of cost information may be used for several years, which is known as the eligibility period. According to the Indiana State Plan, the eligibility period must be at least two years and no more than four years in duration. In state law, OMPP determines the appropriate base year for the DSH program. In 2009, Indiana entered the fourth year of an eligibility period that was based on SFY 2004 cost data. For 2010, a new base year will be used, and the eligibility period is expected to last two years, 2010 and 2011. Hospitals' 2009 cost reports will be used for determining eligibility for the 2010-2011 eligibility period.[4]

Since Medicaid is a jointly administered program, administered by the state within certain federal parameters, the federal criteria have been adopted into state statute and entered into the State Medicaid Plan with certain additions that apply to Indiana.

From the federal guidelines, Indiana has enacted requirements that eligibility for the DSH program be determined based on utilization and revenue data from the most recent year for which an audited cost report is on file with the OMPP. There are various ways to attain DSH eligibility, depending in part on the facility's ownership and type of institution.

(A) An *acute care hospital*, a *state mental health institution*, or a *private psychiatric institution* can be determined as eligible for DSH by meeting criteria involving either the provider's low-income utilization rate (LIUR) or Medicaid inpatient utilization rate (MIUR).

[4]Recent base years have been 2000 (covering an eligibility period of 2000 and 2001, which were calculated based on hospitals' cost report periods ending within SFY 1998); 2002 (covering 2002 and 2003, based on SFY 2000 cost reports); 2004 (covering 2004 and 2005, based on SFY 2002 cost reports); and 2006 (covering 2006, 2007, 2008, and 2009, based on SFY 2004 cost reports).

LIUR Status: The provider's low-income utilization rate is greater than 25%.

LIUR = (provider's Medicaid revenues + cash subsidies received from state and local governments) ÷ (provider's total patient revenues, including cash subsidies)
+
(provider's total charges for inpatient services provided to indigents - cash subsidies received from state and local governments attributable to inpatient services[5]) ÷ (provider's total charges for inpatient services)

MUIR Status: The provider's Medicaid inpatient utilization rate is at least one standard deviation above the mean rate for providers receiving Medicaid payments in Indiana. (Providers meeting the LIUR condition are excluded when calculating the mean MIUR rate.)

MIUR = (provider's total Medicaid inpatient days for most recent year) ÷ (provider's total inpatient days for most recent year)

where Medicaid inpatient days include all acute care days attributable to individuals eligible for Medicaid benefits.

(B) An *acute care hospital* can also attain DSH eligibility by being established under IC 16-22-2 (county-owned) or IC 16-23 (municipally owned) and having a MIUR greater than 1%.

(C) A *community mental health center* (CMHC) that receives county funding and provides inpatient services to Medicaid patients is eligible for DSH payments if the center has a MIUR greater than 1%.

An additional federal requirement for DSH eligibility is that certain providers must have at least two obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. However, there are two exceptions to this federal requirement: (1) The hospital inpatients are predominantly under age 18, and (2) The hospital did not provide nonemergency obstetric services to the general population as of December 22, 1987.

Within these broad categories, several different provider groups are denoted.

- A *Historical* DSH provider (sometimes referred to as the "Class of 1998") is an acute care hospital, either public or private, which was eligible for DSH for FY 1998 and is also eligible for the current period. Historical DSH hospitals currently include Clarian Health Partners, Wishard, Gary Methodist, Fayette Memorial, Huntington Memorial, St. Anthony Memorial, St. Catherine, and St. Margaret Mercy.

- A *nonstate, government-owned or -operated hospital* (NSGO) is either a county-owned hospital established under IC 16-22-2, a hospital established under IC 16-22-8 that is owned and operated by the Health and Hospital Corporation of Marion County (i.e., Wishard), or a municipal hospital established under IC 16-23.

- A *Municipal* DSH provider is an NSGO (i.e., either a county-owned hospital established under IC 16-

[5]The State Plan equation differs from the equation in state statute. The differences will be discussed further in the section *The Indiana Medicaid State Plan*.

22-2 or a municipal hospital established under IC 16-23) with a MIUR greater than 1%. Wishard is not included under the Municipal DSH classification.

- A *Safety Net* hospital is defined in the State Medicaid Plan as an acute care hospital that is eligible for DSH payments. As such, a Safety Net hospital includes both private acute care hospitals and NSGOs.

DSH Payment Caps

Contrary to the structure of payment limits that apply to the UPL program, a hospital that qualifies for DSH payments is subject to a federally imposed cap to limit the payments that an individual hospital can receive. Additional limits on total statewide DSH funding and on total payments to institutions of mental disease (IMD) are also imposed, and these aggregate limits also affect the amount of DSH payments that any individual hospital might receive.

There are three primary federal limitations or caps placed on DSH payments, including:

- A *Hospital-Specific Limit* that caps the amount each hospital can receive.
- The statewide allocation of federal DSH funds.
- An IMD cap on institutions for mental disease equal to 33% of the total state DSH allocation.

DSH payments are supplemental payments to offset hospitals' *uncompensated* costs of serving Medicaid and uninsured individuals. Consequently, each hospital is subject to a hospital-specific limit based on the hospital's amount of service provided to Medicaid and uninsured patients. The hospital-specific limit is calculated to reflect each hospital's cost of providing services to Medicaid recipients and to individuals who are uninsured *less* any related payments, *less* Medicaid payments received, *less* HCI payments received, and *less* UPL payments received.

Order of Payments and Payment Shares

The order of payments can help maximize the amount of federal funding received and provide for equitable distribution of UPL and DSH when there are insufficient funds to pay full share or other limitations to making a full-share payment. The order of payments is authorized in statute, and prior to 2008 the order of supplemental payments was largely prescribed in state statute.[6]

For FY 2008 and years thereafter, OMPP may make payments "in the order of priority that best utilizes available nonfederal share, Medicaid supplemental payments, and Medicaid disproportionate share payments, and may change the order or priority at any time as necessary for the proper administration of one or more of the payment programs."[7] [Descriptions of the order in which the various payment pools were paid for 2000 through the anticipated payment procedure for 2010 are provided in the table provided in Appendix B.]

[6]For FY 2005 and before, the order of payments was established by IC 12-15-20.7-2(a), by IC 12-15-20-2(8)(D) for FY 2006 and FY 2007, and by IC 12-15-20.7-2(b) for FY 2008 and after.

[7]IC 12-15-20.7-2

UPL supplemental and DSH payments are made on a state fiscal year basis (July 1 to June 30). However, DSH allotments are received on a federal fiscal year basis (October 1 to September 30).

Supplemental Payment Pools

Various hospitals are grouped into pools for allocation of supplemental payments. Each pool or grouping is seen in Exhibit 1 and described below. The pools are presented with the funding limits and conditions.

UPL Payments

Private Hospitals with more than 60,000 Medicaid Inpatient Days (UPL Pool #1): According to current statute, private hospitals having more than 60,000 Medicaid inpatient days are paid UPL payments totaling $10 M, which is to be divided equally between inpatient and outpatient pools. Clarian is currently the only hospital falling within this category.

Historical DSH hospitals (UPL Pool #3) are paid UPL payments by agreement with the state. This payment pool consists of hospitals defined in statute as acute care hospitals that were eligible for DSH payments in FY 1998 and that are eligible for DSH for the period being considered. Under agreement with the state, payments are based on inpatient days and case-mix indexes.

Safety Net Hospitals: If UPL funds are insufficient to provide each hospital an amount to pay the hospital's entire Medicaid shortfall amount, payments are prorated so that each hospital receives the same *percentage* of their shortfall amount. Hospitals in this category must be eligible for DSH and are therefore subject to the payment proration criteria described below for private hospitals receiving DSH Payments.

Municipal Hospitals: Generally, municipal hospitals receive payments up to each hospital's entire hospital-specific cap. *The payments can come from either UPL funds or DSH funds or a combination of the two.* For the first time, in FY 2009, the combined UPL and DSH funds were insufficient to pay all of their cap amounts. When there are insufficient funds to pay all of the hospitals' cap amounts, each hospital receives the same percentage of their cap.

Private Hospitals (UPL Pool #2): If there are sufficient UPL funds for payments to this category, the pool for private hospitals is distributed (1) based on each hospital's relative share of the total Medicaid inpatient days for hospitals in the pool or (2) in accordance with another payment methodology determined by OMPP and approved by CMS. A hospital's Medicaid inpatient days are the hospital's in-state and paid Medicaid fee-for-service and managed care days for the state fiscal year.

DSH Payments

Nonstate Psychiatric Hospitals: According to statute, nonstate psychiatric hospitals receive an aggregate $2 M DSH allocation from the IMD pool. (The IMD pool is equal to 33% of the statewide DSH allocation.) The $2 M is distributed to the hospitals based on each hospital's MIUR.

State Psychiatric Hospitals: State mental health institutions generally receive the balance of the IMD DSH pool (up to a statutory maximum of $191 M), which is distributed based on each hospital's low-income utilization rate, or LIUR.

Municipal Hospitals: Municipal hospitals that are eligible for DSH payments.

Private Hospitals: Private hospitals in this category must be determined to be eligible for DSH payments. The State Medicaid Plan requires a payment adjustment for hospitals that have only been eligible for one or two eligibility periods. Hospitals qualifying for DSH for the first time are eligible to receive only 1/3 of the established payment amount. This payment adjustment is in force for the entire eligibility period. If a hospital is determined to be eligible for a second consecutive period, the payment adjustment is 2/3 of the established amount. After the third consecutive eligibility determination, the hospital is entitled to receive 100% of the established payment amount for as many eligibility periods as eligibility is maintained.

Recent History of Supplemental Payments

The payment totals for each pool or category of payee for 2000 through 2009, along with the federal and nonfederal sources of funding associated with those payments, are provided in Appendix C. The most notable feature of the recent payments concerns the change in number and types of hospitals that received payments in 2008 and 2009 compared to prior years.

The number of hospitals receiving supplemental payments of some type has dramatically decreased, largely due to the elimination of the HCI payments and HCI-funded Medicaid add-on payments beginning in 2008. There were 143 hospitals receiving supplemental payments in 2000. Although some hospitals were either eliminated or consolidated with other hospitals over this time period, the number of hospitals receiving supplemental payments declined to 74 by 2009. Even as recently as 2007, there were 149 hospitals receiving payments. The number of hospitals by ownership type and DSH class that received some type of supplemental payments are summarized in the following table.

Exhibit 2. Number of Hospitals Receiving HCI, UPL, or DSH Supplemental Payments by Ownership Type and DSH Class.

Ownership Type	DSH Class	Number of Hospitals Receiving Payments*				
		2000	...	2007	2008	2009
NSGO	Municipal	38	...	38	38	38
NSGO	Not DSH-eligible	6	...	-	-	-
State	Psychiatric	6	...	5	5	5
CMHC	Psychiatric	7	...	8	8	8
Private	Psychiatric	5	...	5	4	4
Private	Historical	8	...	8	7	7
Private	DSH-eligible	11	...	13	13	12
Private	Not DSH-eligible	62	...	72	-	-
Total		143	...	149	75	74

* Some of the hospitals that did not receive payments in 2008 and 2009 may have either gone out of business or were consolidated into other hospitals' systems.

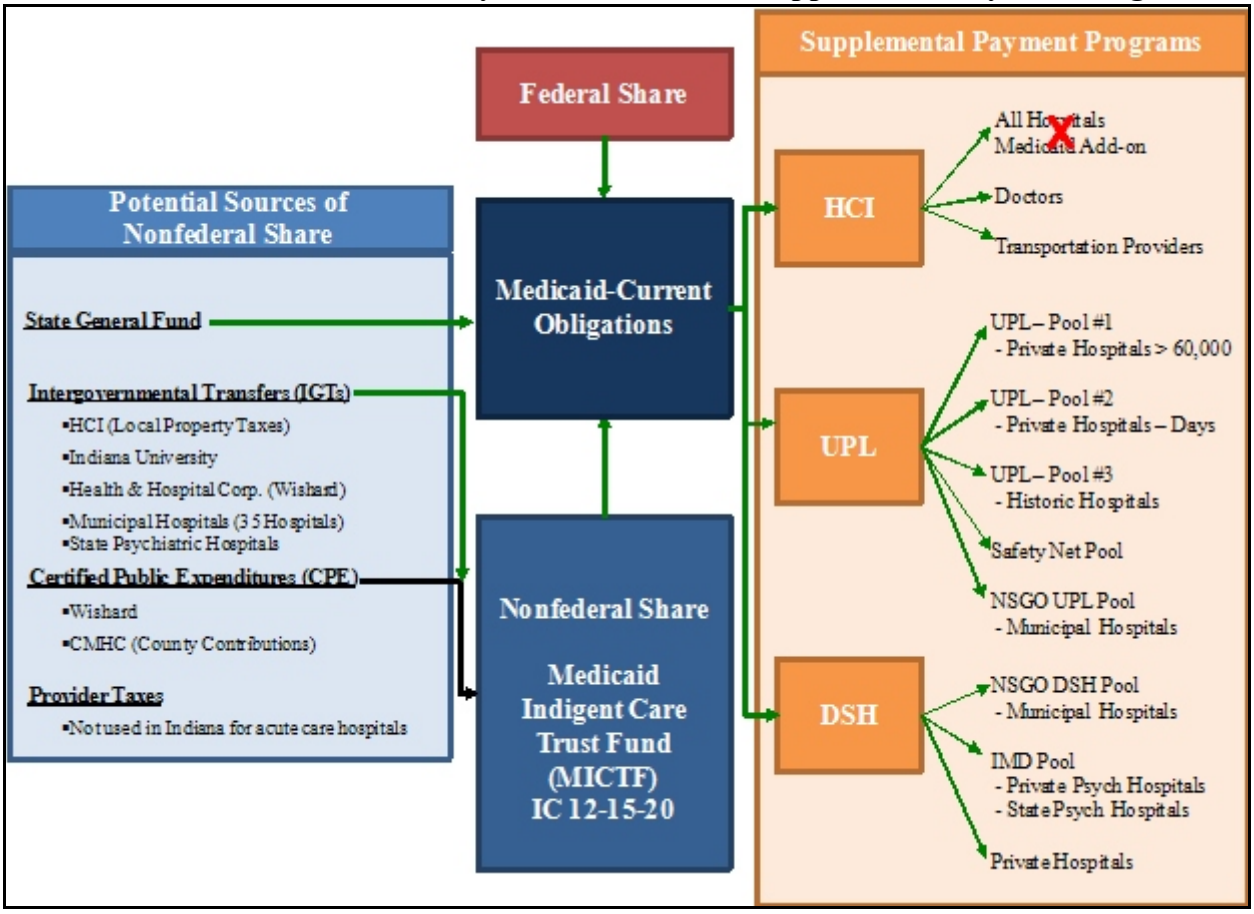
Source: OMPP

Total payments from the HCI, UPL, and DSH programs aggregated for each individual hospital for each year of the ten-year period between 2000 and 2009 are shown in Appendix D.

Supplemental Payments Funding

Exhibit 3 shows the basic Indiana Medicaid supplemental payment programs and the general flow of funds. The federal share is about two-thirds of the funding that supports the state Medicaid supplemental payments. There are multiple potential sources for the nonfederal share for funding supplemental payments. As discussed above, the funds are allocated to one of three programs, and then distributed in various payment programs to hospitals of different types. The payment and funding process will be discussed in this section.

Exhibit 3. Revenue Sources and Payments of Medicaid Supplemental Payment Programs.



Potential Sources of Nonfederal Funding

The supplemental payments in Indiana have been funded with local property tax revenue, intergovernmental transfers from hospitals (IGTs), and certified public expenditures (CPEs). State general revenues have since replaced the use of HCI property taxes in the supplemental programs. The following section describes these funding sources and their contribution to matching federal funds.

A listing of the nonfederal sources of funding for HCI, UPL, and DSH and the associated federal dollars are provided in Appendix C for FY 2000 through FY 2009.

State General Fund

The funding of Medicaid supplemental payments made minimal use of state General Fund appropriations until the HCI property tax levy was eliminated. Expenditures made from appropriations of state General Fund dollars within the biennial state budget can be counted as part of the nonfederal match for supplemental programs. Qualified expenditures by the Division of Mental Health and Addictions and the FSSA administration can count toward the nonfederal share of DSH if they are made by eligible institutions. Certain expenditures made by the state psychiatric hospitals as the nonfederal match are intergovernmental transfers (IGTs).

Intergovernmental Transfers

The largest source of nonfederal funding is IGTs, which are transfers of funds from one governmental entity to another. Thus, IGTs only come from a local unit revenue source, appropriations for a state facility, or a nonstate, governmentally owned and operated hospital and may not come from a private hospital.

The locally generated HCI property tax levies have historically been transferred from each county to the State HCI Fund (the exception being Marion County, which funded its own HCI-type program through the Health and Hospital Corporation). The state HCI funds were later used to make HCI payments directly or were matched with federal funds to make Medicaid add-on payments to hospitals and incorporated into Medicaid rates for doctors and transportation providers. HCI funds were also used to provide the nonfederal match for HCI-funded UPL payments.

Historically in Indiana, supplemental payments have also been funded through IGTs from Indiana University, the Health and Hospital Corporation of Marion County (Wishard), and from the municipal hospitals that receive payments.

Certified Public Expenditures

Certification of public expenditures requires that the expenditure is made by a governmentally owned and operated hospital. It is certified by the entity to the state and used as evidence of an expenditure (both the state and federal shares) that qualifies for federal matching funds.

- Expenditures by the Health and Hospital Corporation have sometimes been certified as the expenditure for municipal hospital UPL and DSH payments.

- County contributions provided to community mental health centers in the past have been certified as expenditure for the IMD DSH pool payments.

Provider Taxes

Provider taxes, while used in other states, are not used for funding hospital supplemental payments in Indiana. [Although not discussed in this report, the nursing home Quality Assessment Fee is a form of provider tax that is used for making supplemental Medicaid payments to Indiana nursing facilities.]

Medicaid Indigent Care Trust Fund (MICTF)

The Medicaid Indigent Care Trust Fund (IC 12-15-20) was established by P.L. 2-1992. The MICTF is a nonreverting fund that was established for the purpose of receiving IGTs from the various governmental entities and then funding the nonfederal share of Medicaid add-on payments and UPL and DSH payments.

- The MICTF can also potentially be used for making Medicaid payments for pregnant women and infants and children.

- Expenses of administering the fund are to be paid from money in the fund, and monies are to be invested in the same manner as other public funds.

Like all Medicaid expenditures, an actual payment must be made to a provider prior to any request for federal reimbursement. No payments are made directly from the MICTF. If the nonfederal share of payments are not funded by an IGT or through a CPE, but rather from the MICTF, the nonfederal share of the payments are transferred to the Medicaid-Current Obligations account to reimburse the state for payment of the nonfederal share.

According to OMPP, the state mental hospitals are paid by the state as calculated and claimed through journal entries by the FSSA Accounting Operations. All other DSH payments are issued through HP (the state's fiscal agent), as calculated by OMPP and Myers and Stauffer (the state's Medicaid rate-setting contractor).

Nonfederal Funding Summary for UPL and DSH

For UPL and DSH, the relative use of each form of nonfederal contribution to supplemental payments varies over time, largely depending on...

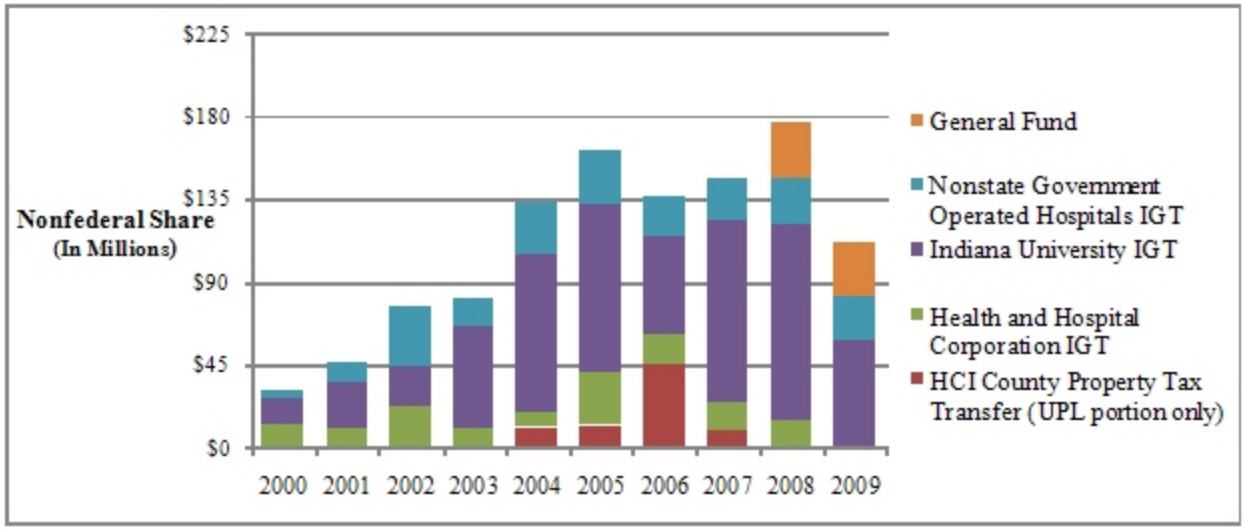
The eligibility determinations of individual hospitals.
The statewide allotment of DSH monies.
The hospital-specific DSH payment limitations.
The payment limitations within the UPL program.
The availability of locally generated tax revenues.
The extent to which state funds are used.
The extent that public hospitals can contribute funds.

Also, the funding mix between the UPL and the DSH programs can be altered to maximize the federal match.[8]

[8]HCI-funded Medicaid add-on payments, which might be considered a form of UPL payment, are not included in this discussion of nonfederal funding since they were funded from a single source of revenue, the Hospital Care for the Indigent property tax levy.

UPL. Historically, the nonfederal share of UPL payments has been largely provided by IGTs from Indiana University and the public hospitals, made by or on behalf of the type of hospital receiving the payments. For example, municipal hospital UPL payments have been typically funded by HCI funds and/or IGTs put up by the municipal hospitals. The private hospital UPL payments have been funded by HCI funds or Indiana University IGTs, since private hospitals cannot by federal regulation put up their own nonfederal share of funding. Hospitals are required to sign agreements with OMPP to ensure that the state is not responsible for a payment to a provider unless IGT is available to fund the state share of the payment.

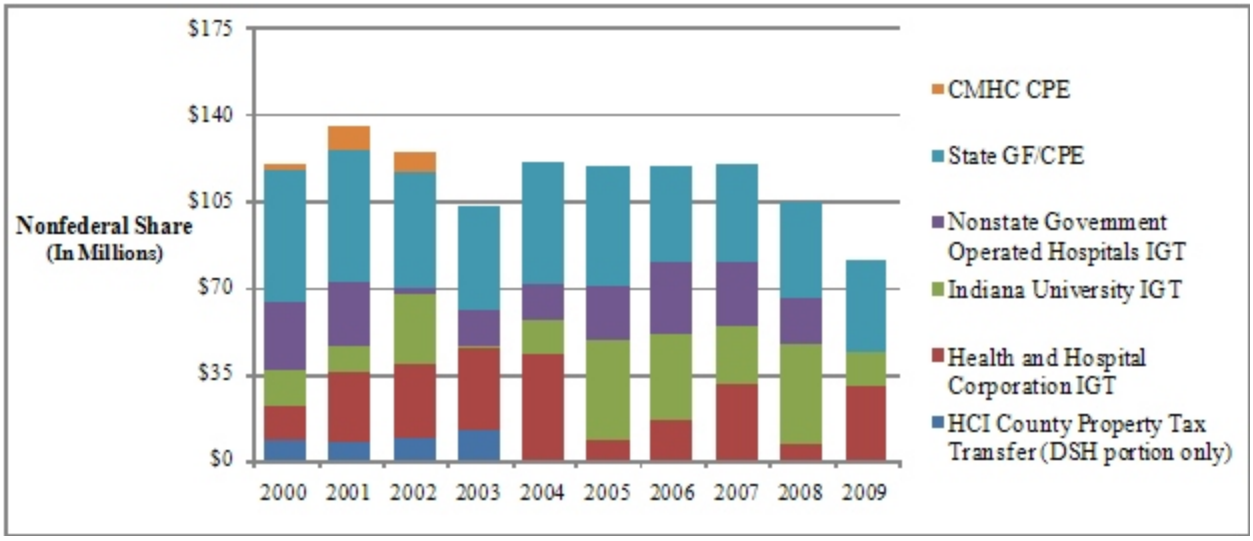
Exhibit 4. UPL Funding Sources, 2000-2009.



HCI property tax revenue was used as a funding source for UPL Pool #2 payments from 2004 through 2007, as shown in Exhibit 4, in addition to its use to fund Medicaid add-on payments to hospitals. The local HCI property tax levy was eliminated by HEA 1001 (2008), with the last scheduled levies being in May and November of 2008 for those billings that were timely. After 2007 until the elimination of the HCI property tax levy, these revenues were used for Safety Net UPL and UPL payments to private, DSH-eligible hospitals. The state HCI Fund continues to be used to receive state General Fund appropriations for use in the UPL and DSH programs, in addition to its use to fund Medicaid add-on payments to hospitals. And the IU IGT has funded a larger share of the total nonfederal source of the UPL for private hospitals over the last ten years.

DSH. The state General Fund contribution to the nonfederal share of DSH expenditures has occurred principally through the DSH payments to the IMD, with some replacement of HCI funding for UPL payments. The nonfederal share for IMD DSH is largely through appropriations to the state mental hospitals and the use of the General Fund for the nonfederal share of payments to nonstate psychiatric hospitals, both private hospitals and some of the CMHCs. NSGO IGTs were not used for DSH in 2009, and very little of the Wishard IGT was used for the UPL in 2009. (In 2009, the NSGOs received no DSH payments as Wishard was the only NSGO hospital receiving DSH. This change is reported to have been made for the benefit of the NSGO hospitals because the receipt of DSH payments would require participation in the newly required and reportedly onerous CMS DSH audit process.) The historical levels of DSH funding sources are depicted in Exhibit 5.

Exhibit 5. DSH Funding Sources, 2000-2009.



Funding Summary

The state General Fund appropriations for the HCI Fund for each of FY 2008 and FY 2009 were $56.9 M, which was increased to $61.5 M for each of FY 2010 and FY 2011. (Approximately $30 M of these appropriations for each fiscal year, corresponding to the amount of HCI funds historically provided to OMPP, are used in the regular Medicaid program rather than for UPL/DSH expenditures.)

HCI property taxes contributed around 10.9% of the nonfederal share before their elimination, while the state share of the nonfederal contribution has ranged from about 31% in the early years of the ten-year period to 34% in 2009, after the HCI elimination. State contributions through direct General Fund expenditures represented about 6% in 2000, but grew to nearly 17% by 2009, largely because of the elimination of the HCI property tax levies as a source of funds. However, indirect funding through appropriations to the state psychiatric hospitals used as IGT represented approximately 25% of the total nonfederal share of supplemental payments in 2000, but 17% in FY 2009.

Indiana University and Wishard, combined, provided about 33.2% of the total nonfederal contribution in 2000. This percentage grew to approximately 60% in 2009. Other NSGOs have contributed 18.3% in 2000, but that share had declined to about 12.5% by 2009.

The relative shares of each type of nonfederal funding are shown in the following table for FY 2000 through FY 2009.

Exhibit 6. Funding Summary, 2000; 2007-2009.

Nonfederal Share (%)	2000	...	2007	2008	2009
HCI Property Taxes	15.2%	...	10.9%	-	-
CMHC/County-funded CPE	1.3%	...	-	-	-
State Contribution - GF	6.3%	...	0.3%	10.9%	16.9%
State Contribution - Appropriations to State Agencies	25.4%	...	13.5%	13.8%	17.3%
Health & Hospital Corp. IGT/CPE - Own Behalf	12.9%	...	15.6%	7.8%	15.8%
Health & Hospital Corp. IGT/CPE - Other Hospitals' Behalf	3.6%	...	0.3%	-	-
Indiana University IGT	16.8%	...	42.5%	52.1%	37.4%
NSGO IGTs - On Own Behalf	8.6%	...	16.9%	15.4%	12.5%
NSGO IGTs - Other Hospitals' Behalf	9.9%	...	-	-	-
Total	100%	...	100%	100%	100%

Source: Office of Medicaid Policy and Planning.

The contributions by all sources (local, state, federal, and hospital funds) are summarized for the years 2000 through 2009 in Appendix C.

The Indiana State Medicaid Plan

The Indiana State Medicaid Plan represents, among other things, the road map for making supplemental payments from various sources of revenue. The State Plan is shaped by both federal and state statute. Federal statute details what a state plan must include. The state legislature provides parameters and the basic structure of the supplemental payment programs through statutory provisions.[9] Additionally, the state legislature may direct the OMPP, through statute or noncode laws, to submit amendments to the State Plan to CMS.

The federal government further shapes the State Plan through negotiations with the state agency in charge of administering the Plan. Also, CMS must review the document for consistency with the state statute and approve the State Plan and any amendments, as well as any waivers from federal requirements, for a state to implement its provisions.

In general, the State Plan reflects the state statute and conforms to federal laws. Several differences, however, between the state statute and the State Plan exist. One such situation concerns the LIUR calculation for DSH eligibility.

As discussed above, LIUR eligibility is determined by summing two fractions. If the sum is greater than the 25% standard, the hospital is a disproportionate share hospital according to state and federal law.

The first fraction concerning the revenues received from government sources, including Medicaid and other subsidies, over the total revenue received is the same in all the references.

[9]Statutory provisions for the UPL and DSH supplemental payments are generally found in IC 12-15-14.5 and IC 12-15-15 through IC 12-15-20.7. HCI-funded payment provisions are found in IC 12-16-7.5.

It is the numerator of the second fraction where the differences occur. Broadly, this equation compares charges for Medicaid patients with the hospital's total charges. The differences among the federal statute, State Plan and state statute are shown in the following table.

42 U.S.C. 1396r–4(b)(3)(B)	Indiana State Plan Attachment 4.19A(K)(2)(A)	IC 12-15-16-3(a)(2)(A) & (b)
Charges for inpatient services attributable to charity care,	Charges for inpatient services attributable to individuals who have no source of payment or third-party or personal resources,	Charges for inpatient services attributable to individuals who have no source of payment,
less contractual allowances and discounts,	less contractual allowances and discounts,	less contractual allowances and discounts.
less governmental cash subsidies reasonably attributable to inpatient hospital services.	less state and local government cash subsidies including HCI payments.	

Overall, the equation in state statute would compute a larger number than either of the other two calculations. A larger result could allow for more hospitals to qualify as LIUR disproportionate share providers. The State Plan definition appears to reduce the numerator the most, making it less likely for hospitals to qualify.

Further, as the state statute is amended, generally, state plans are amended to conform with changes in state statute. However, the 2007 passage of HEA 1678 is not currently reflected in its entirety in the State Plan. HEA 1678 established the Healthy Indiana Program and made several changes to the supplemental payment process. [Details of the changes to supplemental payments in HEA 1678 are described in Appendix A.]

The most significant methodological changes made by HEA 1678 involved moving HCI-funded Medicaid add-on payments from a reimbursement system based on the amount of services rendered to Medicaid patients and the amount of funds transferred to the state HCI fund by each county to a system where the payments are to be equal to the payments each hospital received in SFY 2007, effectively freezing the amount of HCI-funded add-on payments for SFY 2008 and years thereafter. These payments would have extended to all hospitals that received HCI-funded payments in 2007.

OMPP submitted State Plan amendments reflecting HEA 1678 statutory changes to CMS in June 2007.

Although CMS did not object to the fixed supplemental payment amounts, the existing statute at the time[10] along with additional changes in HEA 1678 made the supplemental payments "subject to the availability of funding for the nonfederal share of the payment." According to OMPP, CMS did not approve the State Plan amendment request because CMS no longer allows states to make payments contingent on the availability of funding, requiring instead either a set amount of payments that would be made regardless of the funding or that there be a fixed pool amount coupled with a distribution methodology.

At the time, HCI-funded add-on payments were funded by local HCI property tax collections, which naturally

[10] IC 12-15-15-9(e)

can vary over time.[11] OMPP contended that by establishing fixed payment levels, OMPP would be required to pay the new statutory amounts, regardless of whether enough HCI tax collections were available to fund the nonfederal share of payments.

According to OMPP, the state was unable to reach agreement with hospital providers for the providers to guarantee funding for any differences between the required nonfederal share and the HCI tax collections, and OMPP was unwilling to fund any potential shortfall, as well. As a result, OMPP has made the administrative decision to operate under the previously approved State Plan provisions.

Since the passage of HEA 1678, the later elimination of HCI levies resulted in the state General Fund replacing local property taxes as a funding source for supplemental payments. OMPP has not submitted a State Plan amendment to make payments in accordance with statute after the elimination of the levies.

In several ways, the previously approved State Plan provisions are consistent with changes made by HEA 1678. For example, HEA 1678 amended IC 12-15-15-1.5 to require that nonhistorical, DSH-eligible private hospitals are to receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for DSH in a method that is equitable. The method established in the State Plan specifies a proration of DSH payments based on the number of consecutive periods a hospital qualifies for a DSH payment. A hospital that qualifies for the first time receives 1/3 of the proposed payment amount, for the second consecutive period receives 2/3 of the payment amount, and for the third consecutive period, a full share of the payment. This payment methodology is not specified directly by the state statute. However, OMPP is given wide discretion, both by state and federal statute, to adopt payment policies that will provide equitable payment to the hospitals. And since the State Plan is approved by CMS, it has federal endorsement.

However, in other ways, the State Medicaid Plan for UPL and DSH payments does not match the payment procedure described in statute. One of the minor differences is that UPL Pool #1 is defined in the previously approved State Plan as hospitals with at least 70,000 Medicaid inpatient days, a threshold currently met by only one hospital, Clarian. This threshold was lowered to 60,000 by HEA 1678, although the practical effect of the difference is currently minimal as Clarian is still the only hospital meeting this threshold.

IC 12-15-15-1.5 also defines historical DSH hospitals as those hospitals that were eligible for DSH payments in FY 1998 and *received* DSH payments in 2001, 2002, 2003, and 2004. This is a slightly narrower definition than what is provided in the State Plan, which requires eligibility for DSH in FY 1998, but only must be "*eligible* for a DSH payment in the year for which payments are being calculated."

The most significant impact of the decision to revert to the previously approved State Plan, however, involves the methodology for the distribution of payments to private, non-DSH hospitals. The previously approved State Plan provides that UPL payments for private, non-DSH hospitals are contingent on transfers to the Medicaid Indigent Care Trust Fund from HCI property tax levies. However, subsequent legislation, HEA 1001

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[11]On a statewide basis, the HCI property tax *levies* increased each year from 1999 through 2007. They declined in 2008 because LaPorte County data was not available for 2008. The average annual increase between 1999 and 2007 was 4.46%.

Statewide HCI property tax *collections*, on the other hand, were much more variable during this time period, probably reflecting property tax billing delays. Statewide collections averaged $55.4 M a year between 2000 and 2009, with a low of $42 M in 2004 and a high of nearly $74 M in 2006.

(2008), eliminated the HCI county property tax levies, resulting in the State Plan referencing a statutory provision that is now obsolete. The obsolete code section is IC 12-16-7.5-4.5(b), which applies to SFY 2006 and SFY 2007 and refers to the transfers of HCI tax collections to the HCI Fund as the funding source for payments. IC 12-16-7.5-4.5(c), on the other hand, is the statutory provision applicable to SFY 2008 and years after and references the transfers of funds to the HCI Fund, which could include state appropriations.

As a result, OMPP did not make supplemental payments to private, non-DSH hospitals in 2008 or 2009. State statute, specifically IC 12-15-15-9(d) for Medicaid add-on payments and IC 12-15-15-1.5(c) for UPL supplemental payments, directly provides for supplemental payments to all hospitals providing Medicaid services. As described previously in this paper, where 74 private, non-DSH hospitals received approximately $35.5 M in supplemental payments in 2007[12], none received a supplemental payment in 2008 or 2009. Although IC 12-15-15-1.5(c) as amended by HEA 1678 provides authority to implement alternative payment methodologies in the event that CMS does not approve the statutory procedure, the statute also requires any alternative methodology to be consistent with the methodology prescribed in statute.

Discussion - Healthy Indiana Program and Its Impact on Hospital Payments

The Healthy Indiana Plan (HIP) was enacted into state statute in 2007 (P.L. 218-2007). HIP provides insurance coverage to certain individuals, including childless adults, who might otherwise not have insurance or qualify for Medicaid. [See Appendix E for details of the HIP program.] In order to receive the federal share of Medicaid reimbursement in the HIP program and to provide cost neutrality for the coverage of childless adults, a group not normally covered by Medicaid, the state agreed to waive annual federal DSH distributions above a negotiated base level.[13] This can have several implications for the provision of supplemental payments to Indiana hospitals.

- Although the agreement results in a loss of a portion of the statewide DSH allotment available to safety net hospitals as supplemental payments, there is also a corresponding increase in revenue to hospitals from the provision of services to individuals insured through HIP.

- A temporary increase in federal reimbursement resulting from the enhanced FMAP associated with American Recovery and Reinvestment Act (ARRA) stimulus funding is available through expenditures in the HIP program, while DSH expenditures are not subject to the enhanced FMAP.

- HIP may provide some claims payments to hospitals that otherwise would not have received a supplemental payment because either the hospital was not DSH-eligible or because the discontinuation of HCI-funded Medicaid add-on payments reduced the number of hospitals receiving supplemental payments.

- Unlike UPL and DSH supplemental payments which are restricted to Indiana hospitals, HIP claims payments can be paid to hospitals based in other states.

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[12] Private, non-DSH hospitals received about $25.7 M in Medicaid add-on payments and $9.5 M in UPL payments in 2007.

[13] Healthy Indiana Plan, Centers for Medicare and Medicaid Services Special Terms and Conditions (as amended January 2010), 11-W-00237/5.

- Because the waiver agreement freezes the state DSH allotment, some of the future growth of the DSH allotment may be forgone by the state relative to the future growth of the HIP program, which could have an impact on the revenues to the state's safety net hospitals.

To elaborate on these implications, as a condition of receiving federal financial participation for Medicaid expenditures in the HIP program and to provide cost neutrality for the coverage of childless adults, the state agreed to waive annual federal DSH distributions above a base level of $151,183,400 (federal share) per year. This agreement results in a loss of a portion of the statewide DSH allotment that would otherwise be available to safety net hospitals as supplemental payments. However, the HIP program also provides an opportunity for an increase in revenue to hospitals from the provision of medical services to individuals insured through HIP, and these expenditures would be matched by the federal government.

There is no one-to-one linkage of the waived DSH allotment dollars to the expenditures which can be made through the HIP program. Consequently, any future growth of the forgone DSH allotment above the agreed-to base level relative to the future growth of the HIP program could have an impact on the state's acute care hospital revenues. The actual and preliminary estimates of the state's DSH allocation for FFY 2008 through FFY 2010 are presented in Exhibit 7. For the outlying years through the end of the HIP waiver demonstration in FFY 2013, the terms of the agreement are presented.

Exhibit 7. Federal Share of DSH Allotment Growth, FFY 2008 - FFY 2013

	ARRA DSH Increase	Total DSH Allotment	DSH Base Level Expenditures	Forgone DSH Allotment
FFY 2008	-	$201,335,400	$163,726,400	$37,614,000
FFY 2009[A]	$5,254,854	$210,194,158	$151,183,400	$59,010,758
FFY 2010[B]	$10,641,079	$210,194,158	$151,183,400	$59,010,758
FFY 2011 FFY 2012	The DSH program is limited to the base expenditure level plus any additional FFY 2011 and FFY 2012 DSH allotment that may become available.			
FFY 2013	The DSH allotment is prorated to coincide with the HIP demonstration approval period which terminates December 31, 2012.			

Sources: Healthy Indiana Plan, Centers for Medicare and Medicaid Services Special Terms and Conditions (as amended January 2010), 11-W-00237/5.

[A] For FFY 2009 allotment and HIP allocation - *Federal Register*, Vol. 75, No. 78, Friday, April 23, 2010, p.21325.
[B] For FFY 2010 allotment and HIP allocation - *Federal Register*, Vol. 75, No. 78, Friday, April 23, 2010, p.21326.

The distribution of the funds available for HIP is determined by the individuals who subscribe to HIP and their choice of provider. The hospitals receiving those funds may vary from those that would have received a supplemental payment.

Are HIP Payments Reaching Indiana's Safety Net Hospitals?

A review of claims paid to hospitals through the HIP program shows that in SFY 2009 approximately $99 M total, state and federal, was paid[14]. (This includes both the individual's POWER Account payment and the insurance share.) This compares to forgone DSH expenditures estimated at $92 M[15].

The average federal financial participation on $99 M of expenditures is approximately 73.75%, or about $73 M in federal dollars coming to Indiana. This compares to the forgone DSH allotment of approximately $59 M in federal dollars for FFY 2009.[16]

Medicaid expenditures through the HIP program are enhanced through the American Recovery and Reinvestment Act, while DSH expenditures are not. The average ARRA-enhanced FMAP available for HIP expenditures for FFY 2009 was about 73.75%. This compares to a nonenhanced FMAP available for DSH expenditures of about 64.26%.

In SFY 2009, 74 hospitals received a UPL or DSH supplemental payment, and in FY 2009, 283 hospitals or hospital units received claims payments from HIP. However, a small portion of the HIP payments went to out-of-state hospitals. An estimated 98.7% of the FY 2009 HIP payments, or $97.7 M, went to Indiana hospitals, while about $1.3 M went to hospitals in 21 other states, largely those bordering Indiana.

[14]FSSA request number 7627, HIP Hospital Expenditures, run date: 5/24/2010.

[15] This estimate is based on the $59 M in forgone federal DSH allotment under the waiver agreement matched at a 64.26% federal matching rate.

[16]Since the HIP program was begun January 1, 2008, HIP claims expenditures were only $6.1 M for the six months of SFY 2008. Total HIP expenditures were $99 M for SFY 2009 and $76 M through April 2010 (ten months of SFY 2010).

Exhibit 8. SFY 2009 HIP Claims Payments and Number of Claims by State.

State of Hospital	Total Payments	% of Payments	Number of Claims	% of Claims
Indiana	**$97,727,490**	**98.7%**	**167,421**	**99.6%**
Arizona	1,052	0.0%	6	0.0%
Colorado	405	0.0%	2	0.0%
Florida	17,898	0.0%	7	0.0%
Georgia	45,434	0.0%	2	0.0%
Iowa	1,171	0.0%	4	0.0%
Illinois	**108,750**	**0.1%**	**104**	**0.1%**
Kansas	265	0.0%	2	0.0%
Kentucky	**906,987**	**0.9%**	**360**	**0.2%**
Louisiana	634	0.0%	2	0.0%
Massachusetts	504	0.0%	3	0.0%
Michigan	**32,513**	**0.0%**	**43**	**0.0%**
Minnesota	6,030	0.0%	6	0.0%
Missouri	1,507	0.0%	6	0.0%
Nebraska	646	0.0%	1	0.0%
New Jersey	813	0.0%	2	0.0%
Ohio	**151,297**	**0.2%**	**90**	**0.1%**
South Carolina	566	0.0%	2	0.0%
South Dakota	2,911	0.0%	8	0.0%
Tennessee	22,893	0.0%	22	0.0%
Texas	1,241	0.0%	5	0.0%
Wisconsin	18,152	0.0%	14	0.0%
Total	**$99,049,157**	**100.0%**	**168,112**	**100.0%**

Bolding and shading denotes state is contiguous to Indiana.

Data Source: FSSA.

Regarding Indiana hospitals only, HIP claims payments were made to 144 hospitals based on identified Medicaid provider numbers.[17] More than half of the hospitals (78 or 54.2%) that received a HIP claims payment in SFY 2009 did not receive a Medicaid supplemental payment in SFY 2009. The value of the claims payments to these 78 hospitals was $50.4 M.

[Details of the HIP claims payments by Medicaid provider number are found in Appendix F.]

There were 66 facilities that received a Medicaid supplemental payment in SFY 2009 and HIP claims payments in SFY 2009. Of the 66 facilities, only one had received more from HIP claims payments than from the Medicaid supplemental payments. The total value of the claims payments to hospitals that also received

[17]The claims data identified payments by national provider identifier (NPI), rather than the Medicaid provider number used to identify DSH and UPL payments. The NPI number is a unique identifier and a hospital unit, such as a rehabilitation unit or psychiatric unit, may be identified separately from the overall hospital. To review the claims payments, the hospital units were consolidated under the Medicaid provider number for the hospital.

a supplemental payment was $47.3 M.

The relative future growth rates of the DSH allotments and HIP program expenditures will affect compensation to Indiana's safety net hospitals for indigent care, although the extent of the impact is not known. Future HIP expenditures may be somewhat curtailed by administrative decisions on future enrollment. But the DSH allotments forgone appear to be limited for FFY 2011 and FFY 2012 according to the waiver agreement, which provides that the DSH program expenditures are to be limited to the base expenditure level of $151 M plus any additional FFY 2011 and FFY 2012 DSH allotment that may become available.

Characteristics of Indiana Safety Net Hospitals

The Medicaid supplemental payment programs are designed to provide additional funding to hospitals that form a safety net for Indiana residents. The guidelines and requirements in statute and rules determine which hospitals that provide services to low-income residents will receive additional reimbursement. But these funding mechanisms do not provide information about the characteristics of the safety net. For that, we turned to a 1997 analysis of safety net hospitals prepared using national hospital statistical information from the American Hospital Association.

In the report, "What Types of Hospitals Form the Safety Net" by Linda Fishman,[18] acute care and short-term-stay hospitals from all 50 states were ranked by their ratio of uncompensated care costs to total operating expenses, where uncompensated charges included charity care charges and bad debt. The top 10% of hospitals in the ranking (the highest decile) were then compared with the remaining 90% on several characteristics, including total margin, location, ownership, payer mix, and physician education.

About The Study

The analysis in this paper closely followed the Fishman study, including reproducing the tables of the report for Indiana data. One measure, total margin, was changed in this study to reflect the data available for Indiana, and other exhibits were prepared to provide additional information about Indiana's safety net. One major difference between this report and the Fishman study is that graduate medical education was not reviewed for Indiana.

Methodology

Information used in this analysis came from 2008 reports posted on the Indiana State Department of Health (ISDH) website, including audited financial statements, Medicare cost reports, and hospital fiscal reports. Financial information was primarily drawn from audited financial statements, but the hospital fiscal reports were used when other reports were unavailable. Individual hospital information for hospitals in networks was mostly taken from the hospital fiscal reports.

When a 2008 report was unavailable, the 2007, or in a couple of cases, the 2009 report, was used. In some cases, hospitals or hospital networks were contacted by phone for charity care information.

The hospital fiscal reports are not required to be submitted by hospitals, and mathematical errors were found within the reports. It should be noted that numbers reported among the three sources rarely matched. It is unclear whether the differences resulted from report time periods or differences in definition of items reported.

Generally accepted accounting principles require hospitals to identify charity care charges in the notes to the financial statement. The reported amount is based on the charity care policy of the hospital, which varies from hospital to hospital. While the reporting is uniform, the amount reported reflects hospital policy, which may

[18]Fishman, Linda E., "What Types of Hospitals Form the Safety Net? , Health Affairs, July/August 1997, pp. 215-222.

not be similar.[19] LSA used total charges or Medicaid patient days to allocate charity care charges among hospitals in three separate networks since this information is not provided in the audited financial statements on a hospital-specific basis. Additionally, in cases where the Medicare cost report was not available, LSA used a different year or the average of total charges and total costs of other similarly sized hospitals or other hospitals within a network.

Myers and Stauffer provided some information for 2009 upon the request of LSA. Primarily, patient-day information was used from the Myers and Stauffer data.

ISDH was requested to provide a list of all Indiana licensed hospitals. From the list, only acute care and critical access hospitals were selected, following the methodology of the 1997 analysis which reviewed acute and short-term-stay facilities. Based on this listing, there were 122 hospitals operating in 2008. However, complete data were available or able to be estimated for only 115 hospitals.

Charity care charges, reported in the notes to the audited financial statements, were reduced by the cost-to-charge ratio using the total costs and total charges from Worksheet C, Part I, of the Medicare cost report.[20] This adjusted charity care cost was added to the bad debt expense available in the audited financial report. The sum of the adjusted charity care cost and the bad debt is considered the uncompensated care costs. The uncompensated care costs were then divided by the total operating expense to indicate the relative size of uncompensated costs within the total costs of the hospital.

The hospitals were then ranked by this ratio, and the 12 hospitals (10%) with the largest percentage of uncompensated care costs to total operating costs were separated for comparison with the remaining hospitals. The hospitals were compared on total margin, urban/rural location, ownership, and patient/payer mix.

Patient mix was provided by Myers and Stauffer based on information contained in the Medicare cost reports. For the payer mix, the amount provided in the discussion of net patient service revenues in the audited financial statement was used. Some hospitals, particularly state hospitals, do not include this information, so the breakdown of accounts receivable was substituted. This will shift the focus somewhat from the actual payer mix to the payment policy of the payer. Also used was the gross patient revenue sources from the hospital cost reports when the audited financial statement was unavailable or for consolidation of hospital networks.

The Results

Financial

Hospitals with the highest amount of uncompensated care costs relative to operating expenses (the highest decile) have more than double the burden of uncompensated care when compared with the hospitals in the

[19]Efforts are underway at the Financial Accounting Standards Board (the agency that promulgates generally accepted accounting principles) to provide guidance so that charity care costs, rather than charges, will be reported. This would, in effect, make reporting more uniform across hospitals.

[20]Several hospitals reported charitable costs rather than charges. Every effort was made to identify these hospitals and not reduce the charity costs by the cost-charge ratio.

other deciles. The Indiana hospital results are very similar to the results from the Fishman report, which showed that the highest decile provided double the uncompensated care of all other deciles. Also similar to the Fishman study, although not as strongly demonstrated, Indiana hospitals in the highest decile were more reliant on patient revenue than were the hospitals in the other deciles.

In the study of Indiana hospitals, operating margin was used rather than the total margin that was used in the Fishman report. Operating margin and total margin are both measures of profitability. Operating margin provides information on the stability and efficiency of operations, while total margin can provide information on the viability of the firm as a whole (including investments by the firm). Operating margin was used in this analysis to measure profitability of hospital operations only. The hospitals in the highest decile that provide more uncompensated care overall had a negative operating margin on average, while those in the lower deciles had, for the most part, positive operating margin on average.

Exhibit 9. Financial Statistics of Indiana Hospitals.

Decile	Average percent of total operating expenses that is uncompensated care	Average percent of total operating revenue that is net patient services revenue	Average operating margin	Percentage with negative operating margin
1	22%	97%	-3%	25%
2-10	9%	96%	5%	19%
Detail of Other Deciles				
2	17%	98%	6%	18%
3	14%	98%	9%	9%
4	12%	97%	3%	25%
5	10%	96%	5%	8%
6	9%	94%	5%	17%
7	8%	90%	1%	36%
8	7%	99%	7%	18%
9	6%	96%	-2%	27%
10	2%	94%	8%	17%

In the Fishman study, hospitals in all deciles on average had positive total margins. Both the Fishman study and the Indiana study show variations in the other deciles for operating margin and the percentage with negative margin. In the Indiana study, some of the differences may result from variations in the sources of data used, but may also reflect the diversity of hospitals that make up each decile.

Ownership

Overall, about a third of the hospitals reviewed are owned by local units of government, another third are owned by private nonprofits, and the other third are divided among proprietary and other nonprofit types. Hospitals with the highest amount of uncompensated costs relative to operating expenses tend to be local government-owned (42%) or private nonprofit-owned (33%). Hospitals with the least amount of uncompensated costs tend to be proprietary (58%).

Exhibit 10. Ownership of Indiana Hospitals.

Ownership Type	Decile… 1	2	3	4	5	6	7	8	9	10	All
Local Government	42%	55%	45%	25%	50%	17%	18%	36%	9%	8%	30%
Proprietary	8%	0%	18%	8%	8%	0%	9%	18%	27%	58%	16%
Nonprofit: Church	17%	18%	0%	17%	0%	0%	27%	18%	55%	17%	17%
Nonprofit: Private	33%	18%	18%	33%	25%	75%	45%	18%	9%	17%	30%
Nonprofit: Other	0%	9%	18%	17%	17%	8%	0%	9%	0%	0%	8%

Data Source: ISDH
Note: Percentages may not total due to rounding.

Number of Beds, Hospital Type, and Location

Hospitals in the higher deciles tend to have on average fewer beds than the state average. In part, this is because there are more critical access hospitals in the two highest deciles. About 30% of the hospitals in this analysis are critical access hospitals, but 50.0% of the first decile and 81.8% of the second decile are critical access hospitals.

Exhibit 11. Number of Beds, Hospital Type, and Location of Indiana Hospitals.

	Set Up or Staffed Beds			Hospital Type		Location	
Decile	Average Number of Beds	Minimum	Maximum	Critical Access	Acute Care	Rural	Urban
1	129.8	15	424	50.0%	50.0%	50.0%	50.0%
2	74.8	16	536	81.8%	18.2%	54.5%	45.5%
3	108.1	25	379	27.3%	72.7%	45.5%	54.5%
4	115.3	25	254	25.0%	75.0%	58.3%	41.7%
5	158.3	25	612	25.0%	75.0%	33.3%	66.7%
6	142.8	25	345	25.0%	75.0%	25.0%	75.0%
7	119.6	25	434	27.3%	72.7%	9.0%	91.0%
8	227.9	25	1,312	18.2%	81.8%	45.5%	54.5%
9	238.1	24	795	9.1%	90.9%	18.2%	81.8%
10	152.1	12	425	8.3%	91.7%	0.0%	100.0%
All	**146.4**	**12**	**1,312**	**30.0%**	**70.0%**	**33.9%**	**66.1%**

Data Source: ISDH and http://www.census.gov/population/www/metroareas/lists/2008/List1.txt

Critical access hospitals are designated under the Medicare Rural Hospital Flexibility Grant Program and generally are located in medically underserved or professional shortage areas. A critical access hospital has 25 beds or less, a maximum length of stay of 96 hours, and operates 24-hour emergency services.

Since critical access hospitals tend to be in rural areas, the hospitals in the higher deciles tend to be located in a rural area. Each hospital's location was reviewed by LSA to determine if it was located in a Metropolitan Statistical Area (MSA). Those located in an MSA were labeled urban, and those outside an MSA were labeled rural. These results dovetail well with the findings of the Fishman report, which states, "Small rural hospitals are important in the fabric of the safety net."

Exhibit 12. Location and Bed Size.

Location	Percent in Highest Decile	Percent in All Other Deciles
MSA	50.0%	68.0%
Rural (fewer than 50 beds)	41.7%	17.5%
Rural (50-99 beds)	8.3%	9.7%
Rural (more than 99 beds)	0.0%	4.9%

Source of Payments

Exhibit 12, above, indicates that the hospitals in the highest decile are more reliant on patient revenue, prompting the question of who pays for patient services. A review of payer mix was undertaken by looking at both the average percentage patient days by payer and the percentage of revenue by source.

The hospitals in the highest decile had a higher percentage of Medicare and Medicaid patient days than the hospitals in the other deciles. This corresponds to a lower percentage of other payer days for the highest decile. Payments for Medicaid patients, on the other hand, were the same percentage for both the highest decile and the other deciles. However, when other government and other state payments are considered, the hospitals with the highest percentage of uncompensated care receive more government payments for patient services. The receipt of payments from nongovernmental sources is clearly lower for the highest decile when compared to the other deciles.

Exhibit 13. Payer Mix by Patient Days and Patient Receipts.

	Highest Decile	All Other Deciles
Payer by Patient Days		
Medicare Days	53.3%	52.2%
Medicaid Days	12.1%	8.8%
Other Payer Days	34.6%	39.1%
Payer by % of Gross or Net Patient Receipts		
Medicare Payments	12.8%	9.8%
Medicaid Payments	34.0%	34.0%
Other Government and Other State Payments	5.3%	3.8%
Other Patient and Insurance Payments	48.0%	51.6%

Data Source: Myers and Stauffer; ISDH website
Note: All Other Deciles patient receipts percentages do not total 100% due to lack of data for one hospital.

Medicaid Supplemental Payments

The acute care and short-term-stay hospitals received about 85% of the supplemental payments made to all Indiana hospitals in 2007, 2008, and 2009. The hospitals in the highest decile of hospitals providing uncompensated care and those in the 8th decile received the highest percentage of the payments made to these safety net hospitals. The first decile contains Wishard Hospital, and the 8th decile contains Clarian Health Partners (dba IU, Riley, and Methodist), and the results in this analysis show the differences between the supplemental payment funding policy and the methodology of ranking hospitals based on one

definition of uncompensated care. This model actually permits some business management practices to influence the ranking to the extent that bad debt management can influence the level of bad debt expense.

The change in funding with the takeover of the HCI property tax levy by the state can be seen in the percentage of hospitals receiving a supplemental payment. In 2007, in almost every decile, 100% of the hospitals received some supplemental payment. In 2008 and 2009, the number of hospitals receiving payments is about halved at 47%. The percentage of hospitals receiving payments in 2008 and 2009 is much lower for hospitals that in this study rank lower in the amount of uncompensated care provided.

Exhibit 14. Supplemental Payments by Uncompensated Care Decile.

Decile	Percent Receiving Supplemental Payments 2007	Percent of 2007 Payments	Percent Receiving Supplemental Payments 2008-2009	Percent of 2008 Payments	Percent of 2009 Payments
1	100%	26%	58%	22%	29%
2	100%	8%	82%	9%	9%
3	100%	4%	55%	3%	3%
4	100%	3%	42%	2%	2%
5	100%	7%	67%	6%	7%
6	100%	7%	42%	6%	8%
7	82%	2%	27%	1%	1%
8	100%	35%	45%	42%	32%
9	91%	6%	27%	4%	5%
10	83%	4%	25%	3%	3%
All	96%	84%	47%	86%	85%

Data Source: OMPP.

Summary - Analysis of Indiana Safety Net Hospitals

The results of the Indiana study are similar to many of the findings in the 1997 Fishman study on hospitals nationwide. The top 10% of hospitals providing uncompensated care provide about double the amount of uncompensated care as other hospitals. This is reflected in the payer mix, both by patient days and patient receipts. It is interesting to note that another study, using the same technique as Fishman to find the safety net hospitals, finds that there is some shift of uncompensated care from government and nonprofit hospitals to proprietary hospitals when managed care enters the hospital market.[21] The article suggests that while no single proprietary hospital increases significantly in the amount of uncompensated care provided, as a group, the hospitals contribute more uncompensated care.

The shift in uncompensated care to other hospital ownership types may be reflected in the payer mix by patient receipts, where hospitals that provide less uncompensated care receive about the same percentage

[21]Bazzoli, Gloria J., Lindrooth, Richard C., Kang, Ray, and Hasnain-Wynia, Romana, "The Influence of Health Policy and Market Factors on the Hospital Safety Net," Health Services Research, 41:4, Part I, August 2006, pp. 1159-1180.

of total patient receipts from Medicaid payments. On the other hand, this may reflect that some of the hospitals that provide less uncompensated care may not be financially performing as well as other hospitals in the Indiana study as seen in the data which show hospitals among the lower deciles of uncompensated care having negative operating margins.

For some hospitals in the study, financial management issues may affect the results. For example, during the study, it was found that Washington County Hospital, a government-owned hospital, was purchased by a proprietary owner. The financial data for Washington County Hospital was found to be lacking by audit agencies reviewing the data. The data were used in the study, nonetheless, with the understanding that this was the best representation of the hospital's performance. As another example, if a hospital has a substantial amount of uncollectable receivables, bad debt expense could be driven up if there is a cleanup of the accounts receiveable. In that case, a hospital would rise in the rankings in this study and might outpace another hospital that actually has usually high amount of write-offs that are uncompensated care. The opposite is true for a hospital that better manages its accounts.

Although urban hospitals serve more people, this study shows that rural hospitals are important in the safety net as well. Critical access hospitals, especially, show up as an important component of Indiana's safety net. The smaller size of these critical access hospitals has influence on the highest decile in the study. It is clear that some of the hospitals in the highest decile in the study are not the same hospitals that receive the majority of Medicaid supplemental payments. The supplemental payments are based on factors that are somewhat different than the factors that ranked hospitals in this report.

Conclusion

The funding sources and payment policies of Indiana's three Medicaid supplemental payment programs were reviewed as requested in 2009 legislation. The review found that several legislative changes to the state statute concerning supplemental payments have not been reflected in the Indiana State Medicaid Plan. The state reverted to making supplemental payments based on the methodology in a prior version of the State Plan. The subsequent elimination of a funding source referenced in that prior methodology led to payments to private, non-DSH-eligible hospitals not being made in 2008 and 2009.

The Healthy Indiana Plan, which is not a supplemental payment program but rather provides insurance to individuals, appears to provide funding to some of the hospitals that had not received supplemental payments in 2008 and 2009. However, the HIP program makes insurance payments for patient services based on the provision of Medicaid services, rather than supplemental payments to hospitals. In addition, a small percentage of the HIP payments are going to hospitals outside of, but in states contiguous to, Indiana.

A review of safety net hospitals based on the provision of uncompensated care finds that in Indiana, safety net hospitals tend to be smaller and include rural hospitals.

Appendix A

Legislative History of Medicaid Supplemental Programs in Indiana

Hospital Care for the Indigent

Funding Legislation

- When administration responsibilities were transferred to the state, the state statute was amended to indicate that each county should levy an amount equal to the average of hospital care for the indigent costs between 1984 and 1986. Going forward, the levy was equal to either the prior-year levy, the prior-year levy adjusted by the statewide average growth quotient for assessed property value, or by the average growth quotient for county assessed property value, whichever was greater.

- In CY 2005, a levy reduction was scheduled in conjunction with a program that was never implemented. As a result, the law was changed to maintain the levy levels in CY 2004 through CY 2006. And then, in CY 2007, the levy was to be increased by the three-year assessed value growth quotient for each county.

- An increase in the state Sales Tax provided for several levy takeovers by the state in 2009, including the HCI levy.

Payment Legislation

- 1987: HCI was a claims-based program.

- 1995: Individual hospital claims were eliminated, converting to Medicaid hospital add-on payments based on prior years' claims payment history. About half of the HCI funds were allocated for use as a per diem rate addition to a hospital's base inpatient payment rate. The add-on payment was divided among hospitals on a pro rata basis using Medicaid inpatient days. The formula was expected to keep hospital payments relatively unchanged from prior years while distributing half of the payments through the HCI program and the other half through a hospital per diem add-on.

- 2001: The Uninsured Parent's Program (UPP) was established using funds freed by the elimination of the HCI program. The following year, the HCI program was reinstated, and implementation of the UPP was delayed until June 2004. The UPP program was repealed in 2003.

- 2003: The claims for the HCI program were required to be processed with other Medicaid claims. Payments for physicians and transportation providers were limited to $3M and distributed among service providers within a county based on the county's contribution to the state fund.

  The distribution method was limited by the transfers to the Medicaid Indigent Care Trust

Fund from the county taxes and less the $3M allocated for physician and transportation providers.

- 2007: Hospital payments were frozen at FY 2007 levels, and hospitals were allowed to discontinue submitting claims to OMPP for processing with other Medicaid claims. [Claims processing by OMPP affected county property tax levy calculation, not the hospital add-on payments.] Additionally, HCI funds in excess of the $3M used for direct physician and transportation provider payments would transfer to the MICTF to make UPL payments to private hospitals.

- 2009: Due to the elimination of the HCI property tax levy, the HCI program was defunct as a separate program, and the source of the state match for other Medicaid supplemental payments was replaced by state General Fund dollars.

Upper Payment Limit

Federal History, Legislation, and Rules

UPL payments came into use in the mid-1990s to increase federal funding in response to tightening of DSH program payments. UPL payments directed funds to a hospital to bring payments in line with Medicare rates. Before rules were put into place to limit the practice, some states would aggregate the UPL across all hospital types, and pay the amount only to state- or county-owned hospitals. In some cases, the state would require locals to return all but a portion of the UPL payment, and then the state would use the money for other state purposes. A state could reduce the general fund support for its state hospitals with additional federal matching funds and with little additional state expenditure when a portion of the payment was returned to the state.

Federal rules have been enacted that allow the aggregation of UPL by hospital ownership and type of service (i.e., inpatient and outpatient), limiting the amount of UPL in each category. UPL payments count against the hospital-specific limit for DSH payments. A hospital may receive UPL payments in excess of its hospital-specific limit, but it will not receive a DSH payment. There have been attempts at the federal level to limit UPL payments at the hospital's cost of Medicaid services, but so far no such limit has been enacted.

Indiana History and Legislation

The Medicaid Shortfall Program was established for governmentally owned hospitals in 1998 legislation. The state's share of the program was financed through intergovernmental transfers to the MICTF from participating hospitals.

In 2003 legislation, a UPL program was established for private hospitals. In the same legislation,Wishard received reimbursement of its "Medicaid Shortfall before other county or municipal hospitals.

Wishard and county and municipal hospitals were allowed to certify hospitals' expenditures as eligible for federal financial participation in addition to making monetary intergovernmental transfers in legislation passed in 2007.

Disproportionate Share Hospital Payment Program

Federal History, Legislation, and Rules

The Social Security Act requires state Medicaid plans to develop provider payment rates that, for hospitals, "take into account (in a manner consistent with Section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs."[22] States were required to establish a DSH program in 1981.

There is no single definition of a safety net hospital. Originally, the determination was left to the states, but as of 1987, there are two tests in federal rules to determine if a hospital is eligible for DSH additional payments: (A) Medicaid Inpatient Utilization Rate, and (B) Low-Income Utilization Rate.

Throughout the 1980s and 1990s, some states used DSH to draw down more federal dollars without spending additional state funds. This was done using donations, provider-specific taxes, and IGTs.

During the 1980s, few regulations at the federal level existed to limit DSH payments by the states. Quite to the contrary, the federal government was encouraging states to utilize the program by allowing states to use donations and provider-specific taxes to meet federal match.

Federal limitations on DSH began in 1987, when criteria were established to determine the eligibility of hospitals for DSH funds. In the 1990s, as the federal Medicaid budget mushroomed, DSH underwent several changes to discourage some of the financing schemes that the states had undertaken.

- 1991: The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments banned provider donations and restricted taxes to broadly defined provider groups.

- 1993: The Omnibus Budget Reconciliation Act set hospital-specific limits on the amount of DSH each hospital could receive.

- 1997: The Balanced Budget Act limited the share of DSH that could be paid to state and private psychiatric hospitals and reduced total state DSH allocations for fiscal years 1998 through 2000.

Today, IGTs can still be used because rules that would have put a check on the IGTs were rescinded. Indiana relies on IGTs to supply most of the nonfederal match for the DSH program, while using the state General Fund for other Medicaid supplemental payments.

Indiana History and Legislation

The DSH program in Indiana and the Medicaid Indigent Care Trust Fund were enacted into law in 1991. However, implementation was not allowed unless the federal administrative agency approved an amendment to the State Medicaid Plan and there were adequate funds in the MICTF. The original DSH program had the following features:

A two-tier system, basic and enhanced DSH, was put into place with all qualifying hospitals receiving a

[22]Social Security Act, Title XIX, Sec. 1902(a)(13)(A)(iv).

payment adjustment, and hospitals with more than 25% low-income utilization receiving an additional significant disproportionate share payment.

Disproportionate share providers were assessed a fee for deposit in the MICTF. Hospitals that qualified for an enhanced benefit were assessed 10% of the hospital's annual gross patient revenues, and hospitals that qualified for the basic payment were assessed 3%.

Calculations to determine if a hospital qualified for a disproportionate share payment were based in part on the number of Medicaid and HCI inpatient days.

Since the program was established, the following legislative changes have been made.

- 1992: The assessment system was changed to conform to changes in federal law. The cities of Gary and East Chicago were allowed to impose a City Option Hospital Income Tax for transfer to the MICTF. Additional revenues for the MICTF would come from an allotment from Indiana University, appropriations from the Department of Mental Health, and revenues from Marion County.

  The distribution of funds also changed with payments going to Clarian Health Partners, Wishard, Gary Methodist, St. Catherine, and St. Mary. From the combined federal and state matching funds, the state received the remaining funds of about $34M to use for other Medicaid purposes.

- 1993: The Basic DSH program was divided into six pools of funding for six categories of hospital. The funding for the MICTF was increased, with Indiana University, Marion County, Gary, and East Chicago increasing their payments.

- 1995: Hospital-specific limits were enacted. Also, the City Option Hospital Income Tax for Gary and East Chicago was repealed in 1995. However, the amount available for the MICTF actually increased through larger intergovernmental transfers by Indiana University and Marion County. Adjustments were made to the pools distributed to hospitals, reducing the amount distributed to inpatient psychiatric hospitals to a total of $2 M.

- 1998: DSH programs for municipal hospitals and community mental health centers were created. The municipal hospitals would make intergovernmental transfers to the MITCF, while the county treasurer would certify public payments from county property tax levies for CMHCs.

- 2000: Elimination of the distinctions between the Basic and Enhanced DSH programs occurred. The OMPP was given broad discretion to develop DSH payment methodology.

- 2007: OMPP was given authority to determine a method to equitably distribute DSH if funds were insufficient to fund full shares.

Below, the major provisions of HEA 1678 and their effect on the UPL and DSH programs are detailed.

Major Provisions of HEA 1678 Affecting Supplemental Payments.		
Code Cite	***HEA 1678 Changes***	***Affects***
IC 12-15-15-1.1, -1.3	Removes the requirement to distribute payments in proportion to each hospital's upper payment limit and changes to distribute in an amount not to exceed the hospital's shortfall.	Muni UPL
	Adds the ability for municipal hospitals and NSGOs to use CPEs in addition to IGTs.	
IC 12-15-15-1.5	Lowers the minimum number of Medicaid inpatient days from 70,000 to 60,000 to qualify for UPL Pool #1.	Private UPL
	Defines a hospital's Medicaid inpatient days as being in-state and paid Medicaid fee-for-service and managed care days.	
	Defines Medicaid supplemental payments to be Medicaid payments in addition to fee-for-service, risk-based managed care, and DSH payments, and includes safety-net payments and municipal UPL, private UPL, and HCI-funded add-on payments.	
	For SFY 2008 and after, defines the payment methodology for private hospitals.	
	Provides that subject to the availability of county HCI funds transferred to the MICTF to serve as the nonfederal share, supplemental payments shall be paid to all private hospitals providing services to Medicaid patients. The payments are to be pro rata based on Medicaid inpatient days. *	
	Defines historical DSH hospitals (UPL Pool #3) as those eligible for DSH payments in FY 1998 and received DSH payments in 2001, 2002, 2003, and 2004. Provides that payments are subject to the availability of nonfederal share being provided by or on behalf of the hospital.	
	Specifically provides that for FY 2008 and FY 2009, Gary Methodist Hospital is to receive 100% of the hospital's hospital-specific limit for FY 2005. The remaining historical hospitals are to receive 100% of their hospital-specific limit for FY 2004. For years after FY 2009, payments to the historical hospitals are to be in a manner determined by OMPP.	
	Provides that the remaining amount of funds is to be distributed to nonhistorical, DSH-eligible private hospitals in a manner that best uses federal matching funds. Also specifies that nonhistorical, DSH-eligible private hospitals are to receive payments in a manner that takes into account the situation of eligible hospitals that have historically qualified for DSH and ensures that payments are equitable.	Private UPL
	Provides authority to implement alternative payment methodologies consistent with the methodology provided in this bill in the event that CMS does not approve the methodology provided in this bill. (Also, repealed IC 12-15-15-9.8, which provided a similar, but narrower, authority regarding HCI-funded payments.)	
IC 12-15-15-9, -9.5	Changes HCI-funded Medicaid "add-on payment methodology based on aggregate claims to Medicaid "supplemental payments based on FY 2007 payments. Existing statute makes the payments subject to the availability of funding for the nonfederal share.	All Hospitals Serving Medicaid
IC 12-15-15-10	Removes the authorization to expand the NSGO UPL payment program to include DSH-eligible private hospitals, state mental hospitals, and nonstate psychiatric hospitals.	All DSH Hospitals

Code Cite	*HEA 1678 Changes*	*Affects*
IC 12-15-19-2.1	Removes the requirement for the state to provide from state funds an amount sufficient to generate a minimum total payment of $26 M to acute care hospitals eligible for DSH under LIUR or MIUR criteria.	Certain DSH Hospitals
IC 12-15-19-6	In the event of insufficient IGTs, CPEs, or other deposits into the MICTF or a statewide DSH allocation insufficient to meet all hospital-specific limits, the payment reduction methodology is changed from "reducing payments to all eligible institutions by the same percentage to "reducing payments using an equitable methodology that best uses federal matching funds, takes into account the situation of hospitals that have historically qualified for DSH, and ensures equitable payments.	All DSH Hospitals
IC 12-15-20-2	Specifies the order of payments from the MICTF for FY 2006 and FY 2007. Also specifies the order of payments for FY 2008 and years after as: $30 M to OMPP; HCI add-on payments; municipal UPL; municipal DSH; Private UPL; Safety net UPL; Historical DSH hospitals; and nonhistorical, private DSH hospitals; and SOFs and private psychiatric hospitals.	All Hospitals
IC 12-15-20.7-2	For FY 2008 and years after, extends the authorization OMPP to make payments in the order of priority that best utilizes available nonfederal share, Medicaid supplemental payments, and Medicaid DSH payments, and may change the order of priority at any time necessary for the proper administration of one or more of the payment programs. (Also repealed a similar provision, IC 12-15-20.7-3.)	All Hospitals

* This provision was changed by HEA1001 (2008) to refer to "funds" transferred to the state HCI fund rather than "county funds" transferred, thus allowing for state general funds to be used for the nonfederal match.

Appendix B

HCI / UPL / DSH Payment Descriptions, 2000 - 2010.					
Program	**Pool or Payee**	**2007**	**2008**	**2009**	**2010 (Anticipated)**
HCI	**State Medicaid Program**	$33 M to state Medicaid program to be used for state match.	Final year for local HCI property tax levies. State appropriation increased to $56.9 M.	No local HCI levy. State appropriation equals $56.9 M.	No local HCI levy. State appropriation increased to $61.5 M.
	All Hospitals Serving Indigents	HCI Add-on payments based on claims for qualifying care at hospitals. Claims are priced at Medicaid rates and paid once per year.	No payments were made in 2008. Proposed methodology was not approved by CMS.	No HCI-funded add-on payments were made. (See 2008)	No HCI-funded add-on payments will be made. (See 2008)
UPL	**Private Hospitals (UPL Pool #1)**	$10 M, by statute, split evenly between inpatient and outpatient pools at private hospitals with more than 70,000 Medicaid inpatient days (Clarian is only hospital in this pool).	UPL Pool #1 received entire $10 M.	UPL Pool #1 received entire $10 M.	UPL Pool #1 will receive entire $10 M.
	Private Hospitals (UPL Pool #2)	Paid to private hospitals based on their relative number of Medicaid inpatient days in the state.	State Plan referenced a state statute that was only effective through 2007. No payments were made to UPL Pool #2 in 2008.	No payments were made to UPL Pool #2. (See 2008)	No payments will be made to UPL Pool #2. (See 2008)
	"Historical" DSH Hospitals (UPL Pool #3)	Paid an amount agreed to with the state. Split based on inpatient days and case-mix indexes. (For 2007, this exhausted all UPL funds available to the private hospitals.)	Paid by agreement with state.	Clarian continued to be paid by agreement with the state; however, the other historical providers were paid from the "safety net pool.	Clarian will continue to be paid by agreement with the state, and the other historical providers will be paid from the "safety net pool.
	"Safety Net" Hospitals	Safety Net hospitals received no payments in 2007.	UPL funds were available for private hospitals, so prorated "Safety Net payments were made. They received 26.96% of their HSL caps.	"Safety Net hospitals received 82% of the HSL caps.	"Safety Net payments will likely again be subject to proration, depending on the size of the private UPL pool and the calculated HSL caps.
	Municipal Hospitals (UPL)	Municipal hospitals received 100% of their hospital-specific limit through a combination of UPL and DSH payments. (For 2007, each hospital received the same share of NSGO UPL pool as they received in 2006.)	Municipal hospitals received 100% of their HSL caps. For 2008, each hospital again received the same share of the NSGO UPL pool as they received in 2006.	The NSGO hospital UPL funds plus DSH funds were not sufficient to pay 100% of HSL caps in 2009. Each hospital received 60.2% of their net payment amount (i.e., payments less IGT). All hospitals except Wishard were paid entirely from UPL funds.	The combined NSGO UPL and remaining DSH funds will be lower than the total municipal hospital caps, resulting in prorated payments.

HCI / UPL / DSH Payment Descriptions, 2000 - 2010.					
Program	**Pool or Payee**	**2007**	**2008**	**2009**	**2010 (Anticipated)**
DSH	**Municipal Hospitals (DSH)**	Received the balance of their HSL after payment of the IMD pool (below).	Received the balance of their HSL caps after payment of the IMD pool (below).	Wishard was the only hospital that received DSH funds in 2009.	Combination of UPL and DSH funds will not likely be sufficient to pay full HSL, resulting in proration.
	Private Pscyhiatric Hospitals	Nonstate psychiatric hospitals, by statute, receive $2 M of the IMD pool (which is equal to 33% of total statewide DSH allotment). The $2 M is allocated based on each hospital's MIUR.	Nonstate psychiatric hospitals received $2 M of the IMD pool. Pool was distributed according to each hospital's MIUR.	Nonstate psychiatric hospitals received their usual $2 M distributed according to each hospital's MIUR.	Nonstate psychiatric hospitals will receive their $2 M allotment distributed according to each hospital's MIUR.
	State Psychiatric Hospitals (SOFs)	Remainder of the IMD pool is allocated to the SOFs. (After the IMD pool was paid, municipal hospitals (above) received the balance of their HSL through DSH payments.)	The SOFs received the balance of the entire IMD allotment.	Slightly less than the entire IMD allotment was distributed. SOFs were paid their uncompensated costs. Remaining DSH was paid to the municipal hospitals.	SOFs should receive their entire balance of the IMD allotment. Any DSH funds in excess of the IMD allotment will be allocated to municipal hospitals.
	CMHCs				
	DSH-eligible Private Hospitals	By statute, DSH payments to private hospitals are only made if there is money left over after the state hospitals, the private pscyhs, and the municipal hospitals have received up to their limits. If funds are available, private hospitals, excluding "historicals , receive the remaining funds. If insufficient funds to pay up to HSL caps, payments are prorated at same percentage for all hospitals. (For 2007, private hospitals received 62.79% of their caps.)	In 2008, there were sufficient DSH funds available to provide each DSH-eligible private hospital 44.52% of their remaining cap after considering the hospital's payments from the "safety net distribution. (The same distribution formula was used that was used in 2007.)	Payments to the IMDs and municipal hospitals exhausted all DSH funds. No DSH payments were made to private hospitals.	Payments to the IMDs and municipal hospitals will likely exhaust all DSH funds. No DSH payments are likely to be made to private hospitals.
	Healthy Indiana Program (HIP)		*HIP:* Agreements made in the HIP waiver reduced available DSH funds by approximately $37.6 M for FFY 2008.	*HIP:* Agreements made in the HIP waiver reduced available DSH funds by approximately $59 M for FFY 2009.	The reduction in DSH funds due to the HIP waiver agreement is estimated to be approximately $59.0 M for FFY 2010.

Source: *HCI / UPL / DSH Payment Summary and Calculations: 2000-2010*; OMPP.

HCI / UPL / DSH Payment Descriptions, 2000 - 2010. *(Continued)*					
Program	**Pool or Payee**	**2003**	**2004**	**2005**	**2006**
HCI	**State Medicaid Program**	$22,844,500 paid to state Medicaid program to be used for state match for Medicaid expenditures.	$33 M paid to state Medicaid program to be used for Medicaid expenditures.	$33 M paid to state Medicaid program to be used for Medicaid expenditures.	$33 M paid to state Medicaid program to be used for Medicaid expenditures.
	All Hospitals Serving Indigents	HCI add-on payments based on FY1997 HCI payment. Excess paid to hospitals in counties with HCI tax levies greater than their hospitals' 1997 HCI payments. HCI taxes attributable to each county allocated to hospitals based on Medicaid days from most recent DSH-eligibility calculation.	Change in payment methodology for HCI add-on payments resulted in allocation based on each hospital's indigent care claims, price at Medicaid rates and paid once per year.	Same procedure as 2004.	Same procedure as 2004 and 2005.
UPL	**Private Hospitals (UPL Pool #1)**	Clarian, through agreement with state, received remaining outpatient private UPL funds after all other private DSH-eligible hospitals received their full amounts.	UPL Pool #1 was created in statute, splitting $10 M evenly between inpatient and outpatient pools at private hospitals with more than 70,000 Medicaid inpatient days. (Clarian is only hospital in this pool.)	Same procedure as 2004.	Same procedure as 2004 and 2005.
	Private Hospitals (UPL Pool #2)		UPL Pool #2 created. Consists of private hospitals with payments distributed based on Medicaid inpatient days.	Same procedure as 2004.	Same procedure as 2004 and 2005.
	"Historical" DSH Hospitals (UPL Pool #3)				Defined in statute as DSH-eligible in FY 1998. Under agreement with state, payments based on inpatient days and case-mix indexes.
	"Safety Net" Hospitals	Payment based on each hospital's Medicaid shortfall and number of consecutive periods of eligibility. Payments equaled 100% of what each hospital was eligible to receive.	UPL payments for private hospitals (excluding Clarian) based on each hospital's Medicaid shortfall and consecutive periods of eligibility. Each hospital received entire amount eligible to receive. Clarian received balance of private UPL funds.	Same procedure as 2004.	Safety Net hospitals received no payment in 2006.

HCI / UPL / DSH Payment Descriptions, 2000 - 2010. *(Continued)*					
Program	**Pool or Payee**	**2003**	**2004**	**2005**	**2006**
DSH	**Municipal Hospitals (UPL)**	Municipal hospitals received 100% of their HSL caps through combination of UPL and DSH payments. For 2003 UPL, each hospital received proportional share of hospital's in-state NSGO UPL pool total.	Full amount of NSGO UPL funds distributed to Muni's. Partial UPL payment paid proportionately, based on in-state claims. Amount attributable to out-of-state claims paid to Wishard.	UPL payments to each hospital for in-state claims equaled each hospital's HSL. UPL for out-of-state hospitals paid to Wishard plus funds available in excess of other hospitals' HSLs.	Same as prior year, except after payments were paid proportional to in-state UPL, including Wishard, the NSGO UPL methodology was revised downward. Refund of full amount of the decrease came from Wishard.
	Municipal Hospitals (DSH)	After payment of IMD pool, municipal hospitals,with exception of Wishard, received balance of HSL caps. Wishard paid out of acute DSH pool (below).	Received the balance of their HSL caps after payment of the IMD pool.	Same as 2004.	Same as 2004 and 2005.
	Nonstate Pscyhiatric Hospitals	Nonstate psychiatric hospitals received their usual $2 M distributed according to each hospital's MIUR.	Same procedure as prior year.	Same procedure as prior year.	Same procedure as prior year.
	State Psych Hospitals (SOFs)	Remainder of IMD pool allocated to SOFs.	Same procedure as prior year.	Same procedure as prior year.	Same procedure as prior year.
	CMHCs				
	DSH-eligible Private Hospitals	DSH payments to private hospitals and Wishard made only if funds left over after SOFs, nonstate pscyhs, and municipal hospitals have received up to their limits. Private hospitals receive remaining funds based on HSL and years of eligibility. 2003 federal DSH allotment was lower than previous years. Private hospitals (subject to 1/3) received add'l 2002 amount in lieu of a 2003 payment. Wishard received less than their full cap amount.	DSH payments to private hospitals made only if funds left over after IMD payments and municipal hospitals have received up to their limits. Private hospitals receive remaining funds based on HSL and years of eligibility. For 2004, private hospitals received the amount eligible to receive. Wishard then was paid the remainder, which was less than their cap amount.	Same procedure as 2004. Private hospitals received the amount eligible to receive. Wishard then was paid their entire cap amount.	Private hospitals, excluding "Historical hospitals, received the balance of the DSH allotment, resulting in a prorated distribution.
	HIP				

Source: *HCI / UPL / DSH Payment Summary and Calculations: 2000-2010*; OMPP.

HCI / UPL / DSH Payment Descriptions, 2000 - 2010. *(Continued)*				
Program	**Pool or Payee**	**2000**	**2001**	**2002**
HCI	**State Medicaid Program**	$21,609,000 paid to state Medicaid program to be used for state match for Medicaid expenditures.	$21,609,500 paid to state Medicaid program.	$21,689,500 paid to state Medicaid program.
	All Hospitals Serving Indigents	HCI add-on payments based on FY1997 HCI payment. Excess paid to hospitals in counties with HCI tax levies greater than their hospitals' 1997 HCI payments. HCI taxes attributable to each county allocated to each hospital based on Medicaid days from most recent DSH-eligibility calculation.	Same procedure as 2000.	Same procedure as 2000 and 2001.
UPL	**Private Hospitals (UPL Pool #1)**			
	Private Hospitals (UPL Pool #2)	Outpatient Medicaid shortfall paid to private DSH-eligible hospitals who entered into agreement with the state.		
	"Historical" DSH Hospitals (UPL Pool #3)			
	"Safety Net" Hospitals	CMS approved UPL payment known as "Safety Net for last quarter of FY 2000. Payment equaled 1/4 of inpatient and outpatient Medicaid shortfall amount. Each hospital received amount eligible to receive.	Payment equaled 100% of each hospital's Medicaid shortfall amount.	Payment based on each hospital's Medicaid shortfall and number of consecutive periods of eligibility. Payments equaled 100% of what each hospital was eligible to receive.
	Municipal Hospitals (UPL)	Municipal hospitals received 100% of their hospital-specific limit (HSL) through a combination of UPL and DSH payments. (Each NSGO hospital received a payment equal to the hospital's Medicaid shortfall.)	Municipal hospitals received 100% of their HSL caps through a combination of UPL and DSH payments. For 2001 UPL, each hospital received their proportional share of the hospital's in-state NSGO UPL pool total.	Municipal hospitals received 100% of their HSL caps. For 2002 UPL, each hospital received the proportional share of the hospital's in-state NSGO UPL pool total.
DSH	**Municipal Hospitals (DSH)**	Received the balance of their HSL after payment of the IMD pool (below).	Same procedure as 2000.	Same procedure as 2000 and 2001.
	Nonstate Pscyhiatric Hospitals	Nonstate psychiatric hospitals, by statute, receive $2 M of the IMD pool (which is equal to 33% of total statewide DSH allotment). The $2 M is allocated based on each hospital's MIUR.	Nonstate psychiatric hospitals received $2 M of the IMD pool. Pool was distributed according to each hospital's MIUR.	Nonstate psychiatric hospitals received their usual $2 M distributed according to each hospital's MIUR.
	State Psychiatric Hospitals (SOFs)	Remainder of the IMD pool after payments to private psychs and CMHCs.	The SOFs received their full amount.	The SOFs received their full amount.

HCI / UPL / DSH Payment Descriptions, 2000 - 2010. *(Continued)*				
Program	**Pool or Payee**	**2000**	**2001**	**2002**
	CMHC Pool	Received $6 M of IMD pool, distributed based on amount funded by county CPE up to HSL cap.	CMHCs received remaining DSH allotment up to their caps.	CMHCs received remaining DSH allotment up to their caps.
	DSH-eligible Private Hospitals	DSH payments to private hospitals and Wishard are only made if there is money left over after IMD pool and the municipal hospitals have received up to their limits. If funds are available, private hospitals receive the remaining funds. (For 2000, private hospitals received their full caps. Wishard and Clarian were paid last, receiving less than their caps.)	Private hospitals received their full caps.	DSH payments to private hospitals and Wishard only made if funds left over after IMD pool and municipal hospitals have received up to their limits. Private hospitals receive remaining funds based on HSL and years of eligibility. For 2002, private hospitals received the amount eligible to receive.
	HIP			

Source: *HCI / UPL / DSH Payment Summary and Calculations: 2000-2010*; OMPP.

Appendix C

Supplemental Payment Program [IC 12-15-20.7-2(b)] [(1)]

	Sources of Funding for the Supplemental Payment Programs	2000	2001	2002	2003	2004
Local Funds	HCI Property Taxes for HCI for Medicaid Program, Add-On Payments, and UPL Pools	$25.68	$25.09	$27.33	$32.21	$16.71
	CMHC/County-funded CPE	2.28	9.43	7.83		
State Funds	State General Fund - Medicaid	10.63	10.63	10.55	10.49	10.45
	IGT - Appropriations to State Psychiatric Hospitals	42.98	43.59	37.09	31.64	39.36
Hospital Funds	IGT/CPE from Health and Hospital Corporation (Wishard) - On Wishard's own behalf	21.71	37.34	45.44	42.78	58.03
	IGT/CPE from Health and Hospital Corporation (Wishard) - On behalf of other hospitals	6.04	1.05	7.94	1.58	(5.82)
	IGT from Indiana University - On behalf of other hospitals, including Clarian	28.41	37.35	49.75	55.80	99.56
	IGTs from other NSGOs - On own behalf	14.54	16.53	35.69	29.91	42.12
	IGTs from other NSGOs - On behalf of other hospitals	16.65	18.96	-	-	-
	Total - Nonfederal Share	168.91	199.96	221.62	204.40	260.41
Federal Funds	Total - Federal Share	275.14	327.26	367.70	342.32	447.91

Program	Eligible under IC 12-15-	Recipients of Supplemental Payments	Description	2000	2001	2002	2003	2004
HCI	-20-2(8)(G)(i)	State Medicaid Program		$21.61	$21.61	$21.69	$22.84	$33.00
	-15-9 & -15-9.5	Add-on payments to hospitals		46.74	46.80	49.02	53.48	15.32
UPL	-15-1.5(b)(A)	Private hospitals [>60,000 Medicaid days (>70,000 days prior to FY 2008)] {Clarian}	UPL Pool #1				56.43	10.00
	15-1.5(b)(B)	Private hospitals [based on % of private hospital Medicaid inpatient days]	UPL Pool #2	48.41			-	196.64
	-19-2.1(a)(2)	Historical DSH hospitals [Pool split based on inpatient days & case-mix]	UPL Pool #3				-	-
	15-1.5	DSH-eligible acute care hospitals ["Safety Net hospitals]		24.73	92.45	79.45	99.19	58.66
	-16-1(b)	Municipal hospitals - UPL		8.70	30.79	128.45	65.68	105.14
DSH	-16-1(b)	Municipal hospitals -DSH		29.60	18.36	10.02	38.00	39.20
	-16-1(a)	Private psychiatric hospitals [split $2 M based on relative MIUR]	IMD Pool = up to 33% of statewide DSH cap	2.00	2.00	2.00	2.00	2.00
	-16-1(a)	State psychiatric hospitals (SOFs) [receive the remainder of pool funds]		112.43	114.82	97.70	83.21	104.54
	-16-1(c)	Community Mental Health Centers (CMHCs) [(2)]		6.00	25.34	21.15	--	--
		Healthy Indiana Program (HIP) [diverted DSH allocation]						
	-16-1(a)	DSH-eligible Privates [remainder - up to remaining HSL caps or statewide DSH allotment [(13)]]		165.43	196.66	201.51	148.74	176.82
		Total Payments		**$465.65**	**$548.83**	**$610.99**	**$569.57**	**$741.32**

	Sources of Funding for the Supplemental Payment Programs	2005	2006	2007	2008	2009
Local Funds	HCI Property Taxes for HCI for Medicaid Program, Add-On Payments, and UPL Pools	$20.65	$58.32	$31.59	-	-
	CMHC/County-funded CPE					
State Funds	State General Fund - Medicaid	10.45	0.74	0.74	30.75	32.71
	IGT - Appropriations to State Psychiatric Hospitals	38.61	38.32	38.93	38.80	33.44
Hospital Funds	IGT/CPE from Health and Hospital Corporation (Wishard) - On Wishard's own behalf	18.35	24.84	45.17	22.09	30.44
	IGT/CPE from Health and Hospital Corporation (Wishard) - On behalf of other hospitals	18.34	7.62	0.92	-	-
	IGT from Indiana University - On behalf of other hospitals	131.50	88.41	122.99	146.97	72.28
	IGTs from other NSGOs - On own behalf	51.77	51.20	48.86	43.53	24.22
	IGTs from other NSGOs - On behalf of other hospitals	-	-	-	-	-
	Total - Nonfederal Share	289.67	269.45	289.20	282.13	193.10
Federal Funds	Total - Federal Share	489.24	455.63	485.03	474.06	463.51

Program	Eligible under IC 12-15-	Recipients of Supplemental Payments	Description	2005	2006	2007	2008	2009
HCI	-20-2(8)(G)(i)	State Medicaid Program		$33.00	$33.00	$33.00	-	-
	-15-9 & -15-9.5	Add-on payments to hospitals		21.07	34.74	60.17	0.00	0.00
UPL	-15-1.5(b)(A)	Private hospitals [>60,000 Medicaid days (>70,000 days prior to FY 2008)] {Clarian}	UPL Pool #1	10.00	10.00	10.00	10.00	10.00
	15-1.5(b)(B)	Private hospitals [based on % of private hospital Medicaid inpatient days]	UPL Pool #2	240.91	30.36	19.48	0.00	0.00
	-19-2.1(a)(2)	Historical DSH hospitals [Pool split based on inpatient days & case-mix]	UPL Pool #3	-	233.79	262.14	339.92	166.01
	15-1.5	DSH-eligible acute care hospitals ["Safety Net hospitals]		61.23	-	-	16.54	156.07
	-16-1(b)	Municipal hospitals - UPL		124.95	95.95	101.02	108.45	97.09
DSH[3]	-16-1(b)	Municipal hospitals - DSH		59.45	173.64	162.05	140.60	131.87
	-16-1(a)	Private psychiatric hospitals [split $2 M based on relative MIUR]	IMD Pool = up to 33% of statewide DSH cap	2.00	2.00	2.00	2.00	2.00
	-16-1(a)	State psychiatric hospitals (SOFs) [receive the remainder of pool funds]		103.79	103.51	104.12	103.98	93.57
	-16-1(c)	Community Mental Health Centers (CMHCs) [2]						
		Healthy Indiana Program (HIP) [diverted DSH allocation]					37.60	59.01
	-16-1(a)	DSH-eligible Privates [remainder - up to remaining HSL caps or statewide DSH allotment]		155.51	41.09	53.25	34.70	-
		Total Payments		**$811.91**	**$758.08**	**$807.23**	**$793.79**	**$715.62**

(1) Generally, the payment totals reflect the gross payments. However, when providers use a certified public expenditure to fund payments, the totals reflect the federal share amounts.
(2) CMHCs statutorily hold the residual position for DSH payments; however, CMHCs have not received payments since 2000. CMHCs payments also were made from the IMD pool, along with private psychiatric hospitals and SOFs.

Source: OMPP.

Appendix D

Total Supplemental Payments By Hospital (HCI / UPL / DSH): 2000-2004.								
Medicaid #	**Provider**	**Owner Type**	**DSH Class**	**2000**	**2001**	**2002**	**2003**	**2004**
100268850	Wishard Mem. Hosp.-HHC of Marion Co.	NSGO	Muni	105,597,328	131,472,575	144,472,062	139,554,159	158,812,501
100270110	Porter Memorial Hospital-Valparaiso	NSGO	Muni	5,133,815	5,279,174	12,124,519	12,712,508	17,580,991
100268190	Columbus Regional Hospital	NSGO	Muni	3,317,561	3,414,630	7,481,129	6,544,311	9,014,469
100268970	Clark County Memorial Hospital	NSGO	Muni	1,319,349	4,119,941	10,407,523	5,856,664	8,210,002
100270450	Floyd Memorial Hospital	NSGO	Muni	2,497,441	2,561,519	6,209,506	4,984,720	5,836,052
100270050	Hendricks Regional Health	NSGO	Muni	1,109,875	1,139,684	2,808,146	3,734,495	4,816,035
100270130	Good Samaritan Hospital-Vincennes	NSGO	Muni	3,486,156	4,495,234	5,310,334	6,959,205	5,344,051
100268730	Howard Regional Health Systems	NSGO	Muni	4,820,929	4,960,467	4,252,846	3,272,552	4,265,395
100270300	Riverview Hospital	NSGO	Muni	1,111,028	1,138,171	2,547,740	4,151,258	4,552,461
100269840	Memorial Hospital of Seymour	NSGO	Muni	934,876	953,759	2,459,938	2,687,900	4,391,604
100269870	Major Hospital	NSGO	Muni	1,109,498	1,144,219	2,718,435	2,295,460	3,742,095
100267930	Hancock Mem Hospital & Health Services	NSGO	Muni	1,527,037	1,572,274	1,862,188	1,646,435	2,323,881
100269480	Henry County Memorial Hospital	NSGO	Muni	854,678	956,457	3,036,901	1,500,152	3,450,974
100268530	Dearborn County Hospital	NSGO	Muni	1,111,856	1,144,927	4,079,435	2,806,178	3,206,418
100268040	Dunn Memorial Hospital	NSGO	Muni	1,309,102	1,346,574	2,075,675	2,104,487	2,252,897
100269800	Johnson Memorial Hospital	NSGO	Muni	1,057,300	1,090,052	2,647,680	2,372,223	2,861,663
100269260	Morgan County Memorial Hospital	NSGO	Muni	1,327,968	1,361,167	2,567,523	2,100,280	2,691,720
100269130	Witham Memorial Hospital	NSGO	Muni	620,906	639,927	1,161,405	1,539,329	2,630,980
100269660	Jasper County Hospital	NSGO	Muni	463,934	477,583	761,634	1,416,216	1,879,093
100269180	Memorial Hospital - Logansport	NSGO	Muni	967,569	989,240	2,547,306	1,833,586	2,440,603
100268930	Scott County Memorial Hospital	NSGO	Muni	1,010,124	1,040,042	2,441,950	1,599,629	2,071,594
100268710	Decatur County Memorial Hospital	NSGO	Muni	489,944	522,340	1,560,064	1,774,713	2,056,596
100268250	Harrison County Hospital	NSGO	Muni	697,305	718,755	1,410,570	1,295,755	1,978,569
100269150	Greene County General Hospital	NSGO	Muni	346,587	361,865	840,332	682,275	1,426,550
100268680	Putnam County Hospital	NSGO	Muni	367,233	619,921	1,259,403	1,050,683	1,220,293
100269610	Jay County Hospital	NSGO	Muni	437,476	445,819	1,059,823	1,349,169	1,541,243
100270480	White County Memorial Hospital	NSGO	Muni	959,517	989,482	1,170,968	1,108,452	1,140,499
100269990	Perry County Memorial Hospital	NSGO	Muni	224,178	359,671	1,107,405	926,599	1,283,212
100269720	Washington County Memorial Hospital	NSGO	Muni	1,185,435	1,219,266	1,157,089	1,075,046	1,735,912
100269760	Woodlawn Hospital	NSGO	Muni	638,477	654,605	1,046,235	1,081,674	1,205,917
100269970	Sullivan County Community Hospital	NSGO	Muni	279,291	501,787	1,649,004	846,020	1,226,447
100270180	Wabash County Hospital	NSGO	Muni	884,245	897,872	1,450,101	780,196	1,062,160

Medicaid #	Provider	Owner Type	DSH Class	2000	2001	2002	2003	2004
100269550	Dukes Memorial Hospital	NSGO	Muni	683,034	1,612,978	1,871,232	2,048,759	1,930,462
100269820	Rush Memorial Hospital	NSGO	Muni	325,026	334,101	595,061	282,051	625,513
100270230	Daviess Community Hospital	NSGO	Muni	656,402	675,097	2,950,338	1,739,485	2,188,608
100270350	Pulaski Memorial Hospital	NSGO	Muni	609,126	626,588	578,161	606,443	710,392
100268270	Adams County Memorial Hospital	NSGO	Muni	540,851	553,121	285,782	229,231	783,252
100270160	Tipton County Hospital	NSGO	Muni	342,846	353,128	779,449	945,960	841,401
100268770	Blackford County Hospital	NSGO	-	289,902	299,330	545,462		
100268150	Clay County Hospital	NSGO	-	554,447	95,413			
100269000	McCray Memorial Hospital	NSGO	-	227,178				
100268590	Orange County Hospital	NSGO	-	250,362				
100270270	Randolph County Hospital	NSGO	-	733,927				
100268130	Wells Community Hospital	NSGO	-	223,262	8,338			
100273300	Richmond State Hospital	State	Psych	26,186,617	39,725,630	34,492,142	31,102,595	27,607,608
100273130	Larue Carter State Hospital	State	Psych	15,396,343	16,066,596	16,994,022	13,429,848	12,998,882
100273500	Evansville State Hospital	State	Psych	20,260,312	25,366,232	3,109,508	19,129,042	12,290,525
100273320	Madison State Hospital	State	Psych	20,246,089	26,821,688	22,684,794	17,660,372	16,455,842
100273120	Evansville Psychiatric Children's Center	State	Psych	2,563,970	1,293,679	-	-	-
200042130	Logansport State Hospital	State	Psych	27,779,994	-	-	-	*
100273170	Hamilton Center, Inc.	CMHC	Psych	526,359	3,340,875	2,846,766	102,539	180,275
100273560	Four County Counseling Center	CMHC	Psych	337,410	1,346,274	1,172,049	167,336	240,747
100273390	Grant-Blackford Mental Health	CMHC	Psych	261,511	1,188,700	1,020,879	105,400	268,227
100273160	Wabash Valley Hospital, Inc.	CMHC	Psych	833,622	1,972,570	1,704,491	115,056	270,467
200404950	Northeastern Center/Samara Unit	CMHC	Psych	-	-	-	-	-
100273260	Otis R. Bowen Center	CMHC	Psych	594,258	2,281,213	1,579,372	120,784	186,186
100270770	Madison Hospital Corporation	CMHC	Psych	2,086,465	3,963,652	3,370,702	50,253	109,974
100273510	Oaklawn Psychiatric Center	CMHC	Psych	591,128	2,403,741	2,075,399	197,043	284,121
200484350	Michiana	Private	Psych	-	-	-	-	135,744
100273680	BHC Meadows Hospital	Private	Psych	162,903	295,181	289,864	289,372	-
100273350	Southlake CMHC, Inc.	Private	Psych	504,546	1,990,787	1,744,554	251,100	175,726
100280850	Community Mental Health Center	Private	Psych	324,186	1,851,292	1,596,551	150,749	148,533
200150660	Behavioral Healthcare of Columbus	Private	Psych	97,775	158,188	115,552	118,752	-
200150420	Behavioral Healthcare of Northern Indiana	Private	Psych	115,794	198,319	-	-	-
200240620	Deaconess Cross Pointe	Private	Psych	-	-	332,181	331,617	-

Medicaid #	Provider	Owner Type	DSH Class	2000	2001	2002	2003	2004
200431930	Wellstone Regional Hospital	Private	Psych	-	-	-	-	-
200119790	Clarian Health Partners (Methodist / IU)	Private	Hist	112,183,776	131,779,828	125,316,207	135,368,266	190,518,527
100268630	Methodist Hospitals Northlake Campus	Private	Hist	24,273,072	24,805,756	21,751,520	27,262,477	30,880,674
100268750	St. Margaret Mercy Health Care Ctr-North	Private	Hist	1,813,132	10,303,092	9,741,581	13,530,685	14,637,566
100268310	St. Catherine Hospital	Private	Hist	8,739,820	8,937,405	8,306,486	9,432,060	13,399,766
100269360	St. Anthony Memorial Health Center	Private	Hist	763,158	750,797	5,263,088	5,613,424	9,584,882
100268210	Fayette Regional Health System	Private	Hist	149,566	152,778	1,580,941	2,403,396	2,862,053
100274610	St. Vincent Children's Specialty Hospital	Private	Hist	999,491	1,706,901	1,392,230	2,330,392	2,126,929
100268810	Huntington Memorial Hospital	Private	Hist	152,824	119,758	1,451,312	1,904,766	2,394,550
100269890	Memorial Hospital of South Bend, Inc.	Private	**	1,921,582	1,943,380	7,947,487	3,857,424	13,518,035
100268500	St. Joseph Medical Center - Ft. Wayne	Private	**	763,283	763,283	3,771,868	1,402,799	6,565,030
100269380	St. Joseph Comm. Hosp.-Mishawaka	Private	**	239,147	243,663	4,744,073	2,695,272	4,133,504
100269040	Lafayette Home Hospital	Private	**	433,463	433,463	4,168,373	1,754,997	4,508,008
200272930	St. Vincent Frankfort Hospital, Inc.	Private	**	131,182	135,282	145,627	150,414	1,034,986
100268480	Parkview Hospital, Inc.	Private	**	857,845	857,845	878,293	857,845	10,717,119
200327520	Women's Hospital, The	Private	**	-	-	-	-	1,113,118
200352690	Orange County Hospital	Private	**	58,676	59,201	62,461	67,627	456,156
100268100	Bloomington Hospital, Inc.	Private	**	309,785	319,443	330,653	336,655	1,362,970
100269230	Marion General Hospital	Private	**	949,502	950,704	4,179,760	1,951,715	474,399
100269520	Community Hospital of Anderson	Private	**	391,732	395,748	2,426,944	1,299,994	187,044
200321460	St. Vincent Randolph Hospital, Inc.	Private	**	-	1,480,415	777,474	822,658	28,846
100225240	Starke Memorial Hospital	Private	**	170,997	172,924	173,841	206,414	61,430
100269430	Ball Memorial Hospital	Private	-	1,650,774	1,650,774	1,650,774	1,650,774	999,769
100267990	Bedford Regional Medical Center	Private	-	122,895	123,082	130,120	133,315	38,168
200148140	Behavioral Healthcare of Lebanon	Private	-	177,486				
200384340	Blackford Community Hospital, Inc.	Private	-	85,771	79,919	93,019	103,736	17,481
100268120	Bluffton Regional Medical Center	Private	-	89,640	51,109	113,021	128,595	60,455
100267970	Cameron Memorial Community Hospital	Private	-	54,816	55,115	57,945	59,914	486,412
100425510	Charter BHS of Indianapolis	Private	-	176,316				
100468360	Charter BHS of Jefferson	Private	-	77,969				
100273480	Charter BHS of Lafayette	Private	-	106,087				
100273620	Charter BHS of Northwest Indiana	Private	-	122,623				
100273530	Charter BHS of Terre Haute	Private	-	218,944				

Medicaid #	Provider	Owner Type	DSH Class	2000	2001	2002	2003	2004
100269320	Community Hospital of Bremen	Private	-	6,427	6,382	7,248	7,358	5,123
100270500	Community Hospital South Inc	Private	-	30,448	30,448	30,448	30,448	80,491
100270570	Community Hospital-Munster	Private	-	850,083	852,598	929,423	1,290,684	818,817
100385760	Community Hospitals of Indiana, Inc	Private	-	1,227,274	6,892,235	5,848,339	542,656	772,963
100268390	Deaconess Hospital - Evansville	Private	-	1,486,418	1,564,169	1,660,379	1,350,717	818,393
100269460	DeKalb Memorial Hospital	Private	-	88,029	87,874	95,428	107,599	63,928
100268340	Elkhart General Hospital	Private	-	465,802	468,546	495,657	573,792	702,214
100269630	Gibson General Hospital	Private	-	86,358	83,798	93,580	136,296	27,773
100270430	Goshen General Hospital	Private	-	181,140	181,786	188,165	201,488	176,258
200260180	St. Vincent Jennings Community Hospital	Private	-	127,369	123,204	133,432	162,506	4,569
100269410	Kendrick Memorial Hospital	Private	-	12,883	12,640	13,693	12,233	-
100269210	King's Daughters' Hospital	Private	-	163,022	163,022	163,022	163,022	185,836
100270330	Kosciusko Community Hospital	Private	-	257,972	85,112	180,891	184,654	81,045
100269200	LaGrange Community Hospital	Private	-	24,790	23,769	25,017	25,828	24,692
100269110	LaPorte Hospital Inc.	Private	-	552,443	545,126	569,773	568,278	330,308
100268460	Lutheran Hospital of Indiana	Private	-	533,265	533,265	549,169	533,265	871,018
100268010	Margaret Mary Community Hospital	Private	-	67,456	64,782	74,449	84,706	45,553
200287080	Parkview Noble, A Community Hospital	Private	-	116,320	115,382	122,553	148,286	50,568
100270390	Medical Center of Southern Indiana	Private	-	86,533	86,533	86,533	86,533	37,799
100268610	Memorial Hosp. & Health Care Ctr-Jasper	Private	-	112,932	112,932	112,932	112,932	132,669
100270070	Methodist Hospital - Southlake	Private	-	444,507	446,926	520,823	901,135	860,434
100269700	Reid Hospital & Health Care Services	Private	-	497,216	497,216	497,216	497,216	551,592
200110710	Select Speciality Hosp. of NW Indiana	Private	-	11,021	11,081	12,913	-	-
200324860	St. Anthony Medical Ctr of Crown Point	Private	-	484,368	485,203	510,714	506,154	110,721
200321440	St. Clare Medical Center	Private	-	112,511	113,160	120,512	137,165	54,414
200136190	St. Elizabeth Ann Seton Hospital	Private	**	11,730	11,474	13,104	59,321	30,692
200027550	St. Elizabeth Ann Seton Hospital, Inc.	Private	-	55,000	53,860	84,162	104,627	9,184
100269080	St. Elizabeth Medical Center	Private	-	124,600	124,600	124,600	124,600	89,583
100268070	St. Francis Hospital & Health Centers	Private	-	48,314	48,314	48,314	48,314	447,868
100267950	St. John's Health System	Private	-	490,909	495,637	529,091	630,557	3,511
100269010	St. Joseph Hospital & Health Center	Private	-	269,442	259,934	293,872	334,415	133,336
100268800	St. Josephs Hospital of Huntingburg Inc	Private	-	38,413	38,413	38,413	38,413	18,277
100269940	St. Josephs Reg. Medical Ctr-South Bend	Private	-	1,344,575	1,356,508	1,428,036	1,504,676	1,022,750

Medicaid #	Provider	Owner Type	DSH Class	2000	2001	2002	2003	2004
100269590	St. Joseph's Reg. Medical Ctr-Plymouth	Private	-	145,596	144,948	157,525	183,337	217,179
100466210	St. Margaret Mercy Health Care Ctr-South	Private	-	324,629	325,800	361,568	617,437	272,337
100268660	St. Mary's Medical Center	Private	-	155,878	156,726	182,640	374,876	725,308
100268410	St. Mary's Medical Center of Evansville	Private	-	1,209,633	1,255,286	1,311,777	1,602,810	1,526,843
200348850	St. Vincent Clay Hospital, Inc.	Private	-	63,770	64,009	70,158	77,210	13,246
100268950	St. Vincent Hospital & Health Care Center	Private	-	733,817	733,817	733,817	733,817	1,429,350
100268360	St. Vincent Mercy Hospital - Elwood	Private	-	41,407	42,128	47,226	46,071	11,538
100270250	St. Vincent Williamsport Hospital	Private	-	9,591	9,224	10,112	11,982	6,692
100270200	Terre Haute Regional Hospital	Private	**	143,234	143,350	1,757,801	288,088	276,594
100270730	The Women's Hospital of Indianapolis	Private	-	311	311	311	311	3,138
100270020	Union Hospital -Terre Haute	Private	-	235,189	235,327	247,127	259,365	459,452
100270780	Vencor Hospital - Indianapolis	Private	**	365,365	383,799	251,396	264,902	9,138
100270700	Warrick Hospital Inc	Private	-	136,614	135,467	145,493	130,660	12,554
100268170	West Central Community Hospital	Private	-	51,070	50,899	37,903	58,486	31,846
100270680	Westview Hospital	Private	-	10,921	10,921	10,921	10,921	12,877
100268830	Whitley County Memorial Hospital	Private	-	145,523	145,333	157,889	180,760	61,184
100270410	Winona Memorial Hospital	Private	-	156,544	156,544	156,544	156,544	-
100269500	Wirth Osteopathic Hospital	Private	-	20,764	20,585	21,267	-	-
200544300	Clarian North Medical Center	Private	-	-	-	-	-	-
200505180	Clarian West Medical Center	Private	-	-	-	-	-	-
200817930	Doctors Hospital	Private	-	-	-	-	-	-
200359450	Dukes Memorial Hospital	Private	-					
200328420	Dupont Hospital	Private	-	-	-	-	-	116,085
200266920	Healthsouth Rehab -Chow Ref 200484520	Private	-	-	-	-	-	2,123
100274630	Healthsouth Rehab Hosp Of Terre Haute	Private	-	-	-	-	-	20,215
100270740	Healthsouth Tri-State Rehab Hosp	Private	-	-	-	-	-	21,969
200398730	St. Vincent Heart Center Of Indiana, The	Private	-	-	-	-	-	12,323
200484520	Howard Reg. Health System-West Campus	Private	-	-	-	-	-	-
200310880	Franciscan Physicians Hospital	Private	-	-	-	-	-	369
200410370	Indiana Heart Hospital LLC, The	Private	-	-	-	-	-	14,354
200518770	Indiana Orthopaedic Hospital	Private	-	-	-	-	-	-
100373250	Kindred Hospital - Indianapolis South	Private	-	-	-	-	-	45,322
200836430	Monroe Hospital	Private	-	-	-	-	-	-

Medicaid #	Provider	Owner Type	DSH Class	2000	2001	2002	2003	2004
200524440	Parkview LaGrange Hospital	Private	-	-	-	-	-	-
200445560	Regency Hospital Of Northwest Indiana	Private	-	-	-	-	-	4,292
200097450	Rehabilitation Hosp Of Ft Wayne	Private	-	-	-	-	-	3,277
100274620	Rehabilitation Hospital Of Indiana	Private	-	-	-	-	-	48,045
200509740	Renaissance Specialty Hosp. - Central Ind.	Private	-	-	-	-	-	-
200816530	Saint Catherine Regional Hospital	Private	-	-	-	-	-	-
200079020	Select Speciality Hosp - Beechgrove Inc	Private	-	-	-	-	-	4,661
200107080	Select Specialty Hospital-Evansville	Private	-	-	-	-	-	1,431
100368680	Southern Indiana Rehab Hosp-New Albany	Private	-	-	-	-	-	17,907
200392020	St Vincent Seton Specialty Hospital	Private	-	-	-	-	-	2,538
200413490	St Elizabeth Ann Seton Hosp Of Kokomo	Private	-	-	-	-	-	5,908
200409060	St Johns Health System	Private	-	-	-	-	-	319,147
200473800	St Vincent Carmel Hospital Inc	Private	-	-	-	-	-	12,231
100268560	St. Vincent Frankfort Hospital	Private	-	-	-	757,889	484,186	-
Total Payments				**444,048,443**	**521,673,778**	**568,895,543**	**544,833,367**	**673,137,091**

* Logansport State Hospital received $31,668,841 in 2004, $29,155,840 in 2005, $29,622,588 in 2006, $31,917,282 in 2007, and $30,394,438 in 2008. However, due to a subsequent audit findin, the payments are in the process of being recouped.
** Eligible for DSH at some point on a 1/3, 2/3, 3/3 basis.

Source: OMPP.

Total Supplemental Payments By Hospital (HCI / UPL / DSH): 2000-2009.									
Medicaid #	**Provider**	**Owner Type**	**DSH Class**	**2005**	**2006**	**2007**	**2008**	**2009**	**Total (2000-2009)**
100268850	Wishard Mem. Hosp.- HHC of Marion Co.	NSGO	Muni	142,405,045	132,382,871	132,382,871	112,261,641	135,041,865	1,334,382,918
100270110	Porter Memorial Hospital-Valparaiso	NSGO	Muni	23,987,399	25,019,115	20,858,600	-	-	122,696,121
100268190	Columbus Regional Hospital	NSGO	Muni	11,383,437	11,873,048	11,873,048	11,873,047	9,636,312	86,410,992
100268970	Clark County Memorial Hospital	NSGO	Muni	8,633,724	9,868,638	9,868,638	9,868,638	8,009,509	76,162,626
100270450	Floyd Memorial Hospital	NSGO	Muni	8,579,412	8,948,419	8,948,419	8,948,419	7,262,648	64,776,555
100270050	Hendricks Regional Health	NSGO	Muni	5,978,296	6,235,427	6,235,427	6,235,427	5,060,750	43,353,562
100270130	Good Samaritan Hospital-Vincennes	NSGO	Muni	5,575,284	5,815,081	5,815,081	5,815,081	4,719,592	53,335,099
100268730	Howard Regional Health Systems	NSGO	Muni	5,160,371	5,382,322	5,382,323	5,382,322	4,368,360	47,247,887
100270300	Riverview Hospital	NSGO	Muni	4,749,442	4,953,719	4,953,719	4,953,719	4,020,500	37,131,757
100269840	Memorial Hospital of Seymour	NSGO	Muni	4,581,625	4,778,684	4,778,684	4,778,684	3,878,439	34,224,193
100269870	Major Hospital	NSGO	Muni	4,045,793	4,219,806	4,219,805	4,219,806	3,424,847	31,139,764
100267930	Hancock Mem Hospital & Health Services	NSGO	Muni	3,632,602	3,788,843	3,788,843	3,788,843	3,075,072	27,006,018
100269480	Henry County Memorial Hospital	NSGO	Muni	3,600,295	3,755,146	3,755,146	3,755,146	3,047,723	27,712,618
100268530	Dearborn County Hospital	NSGO	Muni	3,335,988	3,479,471	3,479,471	3,479,471	2,823,982	28,947,197
100268040	Dunn Memorial Hospital	NSGO	Muni	3,267,885	3,408,439	3,408,439	3,408,439	2,766,332	25,348,269
100269800	Johnson Memorial Hospital	NSGO	Muni	3,135,589	3,270,453	3,270,453	3,270,453	2,654,340	25,630,206
100269260	Morgan County Memorial Hospital	NSGO	Muni	2,808,189	2,928,971	2,928,971	2,928,971	2,377,189	24,020,949
100269130	Witham Memorial Hospital	NSGO	Muni	2,744,821	2,862,876	2,862,877	2,862,877	2,323,547	20,249,545
100269660	Jasper County Hospital	NSGO	Muni	2,652,124	2,766,193	2,766,193	2,766,193	2,245,077	18,194,240
100269180	Memorial Hospital - Logansport	NSGO	Muni	2,567,538	2,677,971	2,677,971	2,677,971	2,173,475	21,553,230
100268930	Scott County Memorial Hospital	NSGO	Muni	1,837,700	2,485,464	2,485,464	2,485,464	2,017,233	19,474,664
100268710	Decatur County Memorial Hospital	NSGO	Muni	2,145,583	2,237,866	2,237,865	2,237,866	1,816,280	17,079,117
100268250	Harrison County Hospital	NSGO	Muni	2,080,853	2,170,353	2,170,352	2,170,353	1,761,485	16,454,350
100269150	Greene County General Hospital	NSGO	Muni	1,907,179	1,989,208	1,989,208	1,989,208	1,614,467	13,146,879
100268680	Putnam County Hospital	NSGO	Muni	1,529,618	1,813,997	1,813,997	1,813,997	1,472,263	12,961,405
100269610	Jay County Hospital	NSGO	Muni	1,645,672	1,731,079	1,731,079	1,731,079	1,404,964	13,077,403
100270480	White County Memorial Hospital	NSGO	Muni	1,396,035	1,456,080	1,456,079	1,456,080	1,181,772	12,314,964
100269990	Perry County Memorial Hospital	NSGO	Muni	1,338,735	1,396,316	1,396,315	1,396,316	1,133,267	10,562,014
100269720	Washington County Memorial Hospital	NSGO	Muni	1,394,650	1,454,635	1,454,635	1,454,635	1,082,217	13,213,520
100269760	Woodlawn Hospital	NSGO	Muni	1,258,096	1,312,207	1,312,208	1,312,207	1,065,004	10,886,630
100269970	Sullivan County Community Hospital	NSGO	Muni	1,216,551	1,268,876	1,268,876	1,268,876	1,029,836	10,555,564

Medicaid #	Provider	Owner Type	DSH Class	2005	2006	2007	2008	2009	Total (2000-2009)
100270180	Wabash County Hospital	NSGO	Muni	1,053,714	1,099,035	1,099,035	1,099,035	891,990	10,317,383
100269550	Dukes Memorial Hospital	NSGO	Muni	486,728					8,633,193
100269820	Rush Memorial Hospital	NSGO	Muni	1,045,240	1,090,197	1,090,196	1,090,197	884,817	7,362,399
100270230	Daviess Community Hospital	NSGO	Muni	2,318,784	1,232,829	1,336,446	1,403,167	840,878	15,342,034
100270350	Pulaski Memorial Hospital	NSGO	Muni	930,585	978,880	978,880	978,880	794,471	7,792,406
100268270	Adams County Memorial Hospital	NSGO	Muni	817,143	852,289	852,290	852,289	691,729	6,457,977
100270160	Tipton County Hospital	NSGO	Muni	877,808	915,563	915,563	915,563	371,541	7,258,822
100268770	Blackford County Hospital	NSGO	-						1,134,694
100268150	Clay County Hospital	NSGO	-						649,860
100269000	McCray Memorial Hospital	NSGO	-						227,178
100268590	Orange County Hospital	NSGO	-						250,362
100270270	Randolph County Hospital	NSGO	-						733,927
100268130	Wells Community Hospital	NSGO	-						231,600
100273300	Richmond State Hospital	State	Psych	26,822,068	26,340,419	29,091,985	26,846,421	34,972,289	303,187,774
100273130	Larue Carter State Hospital	State	Psych	17,384,334	16,021,297	13,918,153	18,138,220	20,800,802	161,148,497
100273500	Evansville State Hospital	State	Psych	12,763,965	10,840,978	11,356,196	9,823,881	18,808,277	143,748,916
100273320	Madison State Hospital	State	Psych	15,865,494	9,563,377	8,166,189	8,844,097	17,438,650	163,746,592
100273120	Evansville Psychiatric Children's Center	State	Psych	-	-	-	-	1,546,079	5,403,728
200042130	Logansport State Hospital	State	Psych	29,155,840	29,622,588	31,917,282	30,394,438	-	148,870,142
100273170	Hamilton Center, Inc.	CMHC	Psych	149,342	173,614	197,668	199,577	199,577	7,916,592
100273560	Four County Counseling Center	CMHC	Psych	199,439	153,288	174,527	176,213	176,213	4,143,496
100273390	Grant-Blackford Mental Health	CMHC	Psych	222,203	152,685	173,841	175,520	175,520	3,744,486
100273160	Wabash Valley Hospital, Inc.	CMHC	Psych	224,058	142,373	162,099	163,664	163,664	5,752,064
200404950	Northeastern Center/Samara Unit	CMHC	Psych	-	128,788	146,632	148,049	148,049	571,518
100273260	Otis R. Bowen Center	CMHC	Psych	154,239	112,523	128,113	129,351	129,351	5,415,390
100270770	Madison Hospital Corporation	CMHC	Psych	91,104	60,415	68,786	69,450	69,450	9,940,251
100273510	Oaklawn Psychiatric Center	CMHC	Psych	235,370	56,118	63,893	64,510	64,510	6,035,833
200484350	Michiana	Private	Psych	372,677	272,354	310,091	313,086	313,086	1,717,038
100273680	BHC Meadows Hospital	Private	Psych	82,947	261,303	297,507	300,380	300,380	2,279,837
100273350	Southlake CMHC, Inc.	Private	Psych	145,574	119,170	135,681	136,992	136,992	5,341,122
100280850	Community Mental Health Center	Private	Psych	123,047	107,180	122,030	123,209	123,209	4,669,986
200150660	Behavioral Healthcare of Columbus	Private	Psych	-	-	-	-	-	490,267
200150420	Behavioral Healthcare of Northern Indiana	Private	Psych	-	-	-	-	-	314,113

Medicaid #	Provider	Owner Type	DSH Class	2005	2006	2007	2008	2009	Total (2000-2009)
200240620	Deaconess Cross Pointe	Private	Psych	-	57,400	19,133	-	-	740,331
200431930	Wellstone Regional Hospital	Private	Psych	-	202,787	-	-	-	202,787
200119790	Clarian Health Partners (Methodist / IU)	Private	Hist	232,923,703	188,323,924	209,286,445	257,263,975	176,009,166	1,758,973,817
100268630	Methodist Hospitals Northlake Campus	Private	Hist	40,350,336	37,755,494	40,964,754	45,124,695	40,622,778	333,791,556
100268750	St. Margaret Mercy Health Care Ctr-North	Private	Hist	16,926,425	12,934,612	14,901,028	16,611,320	14,403,365	125,802,806
100268310	St. Catherine Hospital	Private	Hist	13,683,526	11,568,940	14,319,107	14,331,668	13,185,370	115,904,148
100269360	St. Anthony Memorial Health Center	Private	Hist	9,999,612	8,200,618	9,474,241	10,529,791	9,431,524	69,611,135
100268210	Fayette Regional Health System	Private	Hist	3,748,005	2,537,281	2,804,469	3,255,424	2,816,263	22,310,176
100274610	St. Vincent Children's Specialty Hospital	Private	Hist	2,792,999	2,017,470	2,239,896			15,606,308
100268810	Huntington Memorial Hospital	Private	Hist	2,902,379	2,043,283	2,339,424	2,803,804	2,356,238	18,468,338
100269890	Memorial Hospital of South Bend, Inc.	Private	**	14,517,987	12,079,280	14,730,662	12,197,811	17,930,253	100,643,901
100268500	St. Joseph Medical Center - Ft. Wayne	Private	**	6,825,272	5,409,229	6,941,757	5,439,253	9,455,177	47,336,951
100269380	St. Joseph Comm. Hosp.-Mishawaka	Private	**	4,291,590	3,403,165	4,345,795	3,421,827		27,518,036
100269040	Lafayette Home Hospital	Private	**	6,864,106	5,451,067	6,728,661	5,573,438	8,471,569	44,387,145
200272930	St. Vincent Frankfort Hospital, Inc.	Private	**	1,060,505	820,275	1,044,198	951,166	1,342,884	6,816,519
100268480	Parkview Hospital, Inc.	Private	**	12,344,287	13,038,195	16,259,188	11,914,897	18,210,895	85,936,409
200327520	Women's Hospital, The	Private	**	1,279,960	1,354,305	1,571,223	1,254,772	1,758,083	8,331,461
200352690	Orange County Hospital	Private	**	580,043	582,355	753,426	616,159	942,081	4,178,185
100268100	Bloomington Hospital, Inc.	Private	**	935,092	5,075,592	6,437,558	4,091,982	6,391,677	25,591,407
100269230	Marion General Hospital	Private	**	461,991	3,314,918	4,079,625	2,827,191	4,313,292	23,503,097
100269520	Community Hospital of Anderson	Private	**	220,722	2,058,313	2,531,607	2,011,821	2,974,570	14,498,495
200321460	St. Vincent Randolph Hospital, Inc.	Private	**	41,361	590,102	760,291	595,781	939,236	6,036,164
100225240	Starke Memorial Hospital	Private	**	135,970	365,141	550,444	344,059	524,588	2,705,808
100269430	Ball Memorial Hospital	Private	-	1,287,001	1,870,083	1,703,942	-	-	12,463,891
100267990	Bedford Regional Medical Center	Private	-	89,229	75,101	49,437	-	-	761,347
200148140	Behavioral Healthcare of Lebanon	Private	-						177,486
200384340	Blackford Community Hospital, Inc.	Private	-	24,353	60,791	31,877	-	-	496,947
100268120	Bluffton Regional Medical Center	Private	-	95,462	118,502	132,559	-	-	789,343
100267970	Cameron Memorial Community Hospital	Private	**	534,247	98,012	69,135	-	-	1,415,596
100425510	Charter BHS of Indianapolis	Private	-						176,316
100468360	Charter BHS of Jefferson	Private	-						77,969
100273480	Charter BHS of Lafayette	Private	-						106,087
100273620	Charter BHS of Northwest Indiana	Private	-						122,623

Medicaid #	Provider	Owner Type	DSH Class	2005	2006	2007	2008	2009	Total (2000-2009)
100273530	Charter BHS of Terre Haute	Private	-						218,944
100269320	Community Hospital of Bremen	Private	-	6,655	10,193	5,515	-	-	54,901
100270500	Community Hospital South Inc	Private	-	98,728	102,100	216,909	-	-	620,020
100270570	Community Hospital-Munster	Private	-	916,740	1,840,368	2,256,405	-	-	9,755,118
100385760	Community Hospitals of Indiana, Inc	Private	-	1,151,022	1,438,357	1,658,660	-	-	19,531,506
100268390	Deaconess Hospital - Evansville	Private	-	1,164,895	782,003	1,437,496	-	-	10,264,470
100269460	DeKalb Memorial Hospital	Private	-	74,197	93,049	64,288	-	-	674,392
100268340	Elkhart General Hospital	Private	-	880,371	1,137,997	1,413,597	-	-	6,137,976
100269630	Gibson General Hospital	Private	-	34,254	60,081	98,456	-	-	620,596
100270430	Goshen General Hospital	Private	-	235,372	354,948	265,467	-	-	1,784,624
200260180	St. Vincent Jennings Community Hospital	Private	-	5,995	9,075	3,778	-	-	569,928
100269410	Kendrick Memorial Hospital	Private	-	-	-	-	-	-	51,449
100269210	King's Daughters' Hospital	Private	-	478,255	522,113	570,941	-	-	2,409,233
100270330	Kosciusko Community Hospital	Private	-	312,090	238,988	421,358	-	-	1,762,110
100269200	LaGrange Community Hospital	Private	-	22,826	-	-	-	-	146,922
100269110	LaPorte Hospital Inc.	Private	-	457,249	566,705	691,199	-	-	4,281,081
100268460	Lutheran Hospital of Indiana	Private	-	1,210,192	1,471,872	1,888,282	-	-	7,590,328
100268010	Margaret Mary Community Hospital	Private	-	52,362	68,808	96,151	-	-	554,267
200287080	Parkview Noble, A Community Hospital	Private	-	88,642	116,337	183,969	-	-	942,057
100270390	Medical Center of Southern Indiana	Private	-	49,243	67,106	2,544	-	-	502,824
100268610	Memorial Hosp.& Health Care Ctr-Jasper	Private	-	266,854	544,329	680,430	-	-	2,076,010
100270070	Methodist Hospital - Southlake	Private	-	932,975	-	-	-	-	4,106,800
100269700	Reid Hospital & Health Care Services	Private	-	918,362	1,162,482	1,430,652	-	-	6,051,952
200110710	Select Speciality Hospital of NW Indiana	Private	-	-	-	-	-	-	35,015
200324860	St. Anthony Medical Ctr of Crown Point	Private	-	475,639	703,964	1,380,430	-	-	4,657,193
200321440	St. Clare Medical Center	Private	-	40,801	73,507	48,413	-	-	700,483
200136190	St. Elizabeth Ann Seton Hospital	Private	-	19,801	53,268	30,400	-	-	229,790
200027550	St. Elizabeth Ann Seton Hospital, Inc.	Private	-	-	-	-	-	-	306,833
100269080	St. Elizabeth Medical Center	Private	-	294,014	329,257	404,148	-	-	1,615,402
100268070	St. Francis Hospital & Health Centers	Private	-	1,064,604	1,039,235	1,681,156	-	-	4,426,119
100267950	St. John's Health System	Private	-	-	-	-	-	-	2,149,705
100269010	St. Joseph Hospital & Health Center	Private	-	161,133	246,901	303,321	-	-	2,002,354
100268800	St. Josephs Hospital of Huntingburg Inc	Private	-	28,196	23,489	9,076	-	-	232,690

Medicaid #	Provider	Owner Type	DSH Class	2005	2006	2007	2008	2009	Total (2000-2009)
100269940	St. Josephs Reg. Medical Ctr-South Bend	Private	-	1,178,016	1,862,380	2,512,581	-	-	12,209,522
100269590	St. Joseph's Reg. Medical Center-Plymouth	Private	-	169,333	287,359	419,240	-	-	1,724,517
100466210	St. Margaret Mercy Health Care Ctr-South	Private	-	293,152	371,103	830,701	-	-	3,396,727
100268660	St. Mary's Medical Center	Private	-	587,722	867,573	1,252,286	-	-	4,303,009
100268410	St. Mary's Medical Center of Evansville	Private	-	2,249,601	2,380,864	3,160,514	-	-	14,697,328
200348850	St. Vincent Clay Hospital, Inc.	Private	-	15,015	16,721	6,688	-	-	326,817
100268950	St. Vincent Hospital & Health Care Center	Private	-	1,776,265	2,298,284	2,818,743	-	-	11,257,910
100268360	St. Vincent Mercy Hospital - Elwood	Private	-	14,740	16,797	9,076	-	-	228,983
100270250	St. Vincent Williamsport Hospital	Private	-	11,055	15,748	16,682	-	-	91,086
100270200	Terre Haute Regional Hospital	Private	-	416,188	451,692	341,138	-	-	3,818,085
100270730	The Women's Hospital of Indianapolis	Private	-	-	-	-	-	-	4,382
100270020	Union Hospital -Terre Haute	Private	-	755,323	1,009,743	1,303,846	-	-	4,505,372
100270780	Vencor Hospital - Indianapolis	Private	-	3,135	7,497	8,034	-	-	1,293,266
100270700	Warrick Hospital Inc	Private	-	9,758	16,031	24,372	-	-	610,949
100268170	West Central Community Hospital	Private	-	46,998	70,968	98,435	-	-	446,605
100270680	Westview Hospital	Private	-	16,996	32,224	18,804	-	-	124,585
100268830	Whitley County Memorial Hospital	Private	-	115,646	102,729	167,774	-	-	1,076,838
100270410	Winona Memorial Hospital	Private	-	-	-	-	-	-	626,176
100269500	Wirth Osteopathic Hospital	Private	-	-	-	-	-	-	62,616
200544300	Clarian North Medical Center	Private	-	-	77,469	130,474	-	-	207,943
200505180	Clarian West Medical Center	Private	-	8,140	50,506	225,409	-	-	284,055
200817930	Doctors Hospital	Private	-	-	-	2,562	-	-	2,562
200359450	Dukes Memorial Hospital	Private	-	48,677	161,177	283,944	-	-	493,798
200328420	Dupont Hospital	Private	-	185,915	267,195	365,524	-	-	934,719
200266920	Healthsouth Rehab -Chow Ref 200484520	Private	-	-	-	-	-	-	2,123
100274630	Healthsouth Rehab Hosp Of Terre Haute	Private	-	17,216	19,269	7,513	-	-	64,213
100270740	Healthsouth Tri-State Rehab Hosp	Private	-	26,456	25,384	15,547	-	-	89,356
200398730	St. Vincent Heart Center Of Indiana, The	Private	-	18,866	50,538	704,708	-	-	786,435
200484520	Howard Reg. Health System-West Campus	Private	-	4,345	-	-	-	-	4,345
200310880	Franciscan Physicians Hospital	Private	-	14,520	29,659	9,294	-	-	53,842
200410370	Indiana Heart Hospital LLC, The	Private	-	24,861	58,238	53,005	-	-	150,458
200518770	Indiana Orthopaedic Hospital	Private	-	1,485	10,456	4,647	-	-	16,588
100373250	Kindred Hospital - Indianapolis South	Private	-	69,742	84,242	69,789	-	-	269,095

Medicaid #	Provider	Owner Type	DSH Class	2005	2006	2007	2008	2009	Total (2000-2009)
200836430	Monroe Hospital	Private	-	-	-	11,508	-	-	11,508
200524440	Parkview LaGrange Hospital	Private	-	4,345	41,304	49,652	-	-	95,301
200445560	Regency Hospital Of Northwest Indiana	Private	-	21,176	-	1,042	-	-	26,510
200097450	Rehabilitation Hosp Of Ft Wayne	Private	-	16,721	15,849	5,559	-	-	41,406
100274620	Rehabilitation Hospital Of Indiana	Private	-	86,848	148,756	104,053	-	-	387,702
200509740	Renaissance Specialty Hosp.-Central Ind.	Private	-	5,720	-	13,246	-	-	18,966
200816530	Saint Catherine Regional Hospital	Private	-	-	6,445	26,665	-	-	33,110
200079020	Select Speciality Hosp - Beechgrove Inc	Private	-	-	-	-	-	-	4,661
200107080	Select Specialty Hospital-Evansville	Private	-	-	-	3,170	-	-	4,601
100368680	Southern Indiana Rehab Hosp-New Albany	Private	-	15,675	41,825	8,382	-	-	83,789
200392020	St Vincent Seton Specialty Hospital	Private	-	17,051	33,934	27,360	-	-	80,883
200413490	St Elizabeth Ann Seton Hosp Of Kokomo	Private	-	19,801	-	14,722	-	-	40,431
200409060	St Johns Health System	Private	-	341,281	433,936	713,390	-	-	1,807,754
200473800	St Vincent Carmel Hospital Inc	Private	-	44,881	99,272	134,864	-	-	291,248
100268560	St. Vincent Frankfort Hospital	Private	-	-	-	-	-	-	1,242,075
Total Payments				**777,107,529**	**713,954,771**	**764,562,006**	**726,138,252**	**656,608,880**	**6,390,959,660**

** Eligible for DSH at some point on a 1/3, 2/3, 3/3 basis.

Source: OMPP.

Appendix E

Details of the Healthy Indiana Plan

The Healthy Indiana Plan was approved as a section 1115 Medicaid Demonstration project for a five-year period, January 1, 2008, through December 31, 2012. The population of children, parents, and pregnant women receiving services under the 1915(b) waiver for capitated managed health care plans (Hoosier Healthwise) was transferred from that waiver to the HIP waiver.

HIP provides a high-deductible health plan and an account similar to a health savings account, referred to as a POWER Account. Covered individuals include uninsured custodial parents up to 200% of the federal poverty level (FPL). Custodial parents with resources above the TANF resource limit of $1,000 are also eligible for HIP.

HIP is also available for a limited population of 34,000 uninsured noncustodial parents and childless adults with family incomes up to 200% of FPL. Care is provided within the managed care organizations, and continuing coverage is contingent upon covered individuals paying premiums as applicable. As a Medicaid waiver, the program is eligible for matching federal funds, including enhanced funding due to the ARRA.

In order to provide cost neutrality for the coverage of childless adults, a group not normally covered by Medicaid, and to receive federal Medicaid reimbursement in the HIP program, the state agreed to waive annual federal DSH distributions above a negotiated base level of about $151 M. The state must also demonstrate additional savings of $15 M after five years in other areas of the program as identified in the Special Terms and Conditions that govern the waiver.

Appendix F

Supplemental Payments and HIP Claims Payments							
Medicaid #	Hospital Name	Ownership*	DSH Class*	2007 Supplemental Payment	2009 Supplemental Payment	2009 HIP Claims Payment	2009 No. of HIP Claims Payments
100268270	Adams County Memorial Hospital	NSGO	Muni	852,290	691,729	193,042	970
100269430	Ball Memorial Hospital	Private	-	1,703,942	-	3,419,814	4,818
100267990	Bedford Regional Medical Center	Private	-	49,437	-	650,031	3,422
100273680	BHC Meadows Hospital	Private	Psych	297,507	300,380	81,624	32
200384340	Blackford Community Hospital, Inc.	Private	-	31,877	-	321,170	770
100268100	Bloomington Hospital, Inc.	Private	1/3	6,437,558	6,391,677	2,171,689	3,490
100268120	Bluffton Regional Medical Center	Private	-	132,559	-	204,563	479
100267970	Cameron Memorial Community Hospital	Private	-	69,135	-	282,546	547
200119790	Clarian Health Partners, Inc. (Methodist / IU Merged)	Private	Hist	209,286,445	176,009,166	6,670,373	7,450
200544300	Clarian North Medical Center	Private	-	130,474	-	641,671	324
200505180	Clarian West Medical Center	Private	-	225,409	-	349,103	815
200924720	Clarian-Arnett Health Systems**	#N/A	#N/A	#N/A	#N/A	334,944	170
100268970	Clark County Memorial Hospital	NSGO	Muni	9,868,638	8,009,509	1,208,595	1,342
100268190	Columbus Regional Hospital	NSGO	Muni	11,873,048	9,636,312	387,120	889
100269520	Community Hospital of Anderson	Private	1/3	2,531,607	2,974,570	1,424,941	2,885
100269320	Community Hospital of Bremen	Private	-	5,515	-	89,954	132
100270500	Community Hospital South Inc	Private	-	216,909	-	1,077,396	1,018
100270570	Community Hospital-Munster	Private	-	2,256,405	-	1,904,496	2,392
100385760	Community Hospitals of Indiana, Inc	Private	-	1,658,660	-	2,957,302	2,787
100280850	Community Mental Health Center	Private	Psych	122,030	123,209	35,022	182
100270230	Daviess Community Hospital	NSGO	Muni	1,336,446	840,878	343,530	1,491
200240620	Deaconess Cross Pointe	Private	Psych	19,133	-	2,460	1
100268390	Deaconess Hospital - Evansville	Private	-	1,437,496	-	1,914,768	3,028
100268530	Dearborn County Hospital	NSGO	Muni	3,479,471	2,823,982	381,326	1,552
100268710	Decatur County Memorial Hospital	NSGO	Muni	2,237,865	1,816,280	452,246	1,087
100269460	DeKalb Memorial Hospital	Private	-	64,288	-	193,636	662
200817930	Doctors Hospital	Private	-	2,562	-	101,059	79
200359450	Dukes Memorial Hospital	Private	-	283,944	-	1,035,106	1,641
100268040	Dunn Memorial Hospital	NSGO	Muni	3,408,439	2,766,332	533,195	1,116
200328420	Dupont Hospital	Private	-	365,524	-	894,014	797

Medicaid #	Hospital Name	Ownership*	DSH Class*	2007 Supplemental Payment	2009 Supplemental Payment	2009 HIP Claims Payment	2009 No. of HIP Claims Payments
100268340	Elkhart General Hospital	Private	-	1,413,597	-	2,008,953	1,892
100273450	Fairbanks Hospital	#N/A	#N/A	#N/A	#N/A	374,261	297
100268210	Fayette Regional Health System	Private	Hist	2,804,469	2,816,263	602,821	2,253
100270450	Floyd Memorial Hospital	NSGO	Muni	8,948,419	7,262,648	947,664	1,188
100273560	Four County Counseling Center	CMHC	Psych	174,527	176,213	49,252	16
200310880	Franciscan Physicians Hospital	Private	-	9,294	-	337,415	15
100269630	Gibson General Hospital	Private	-	98,456	-	323,051	862
100270130	Good Samaritan Hospital-Vincennes	NSGO	Muni	5,815,081	4,719,592	823,753	1,952
100270430	Goshen General Hospital	Private	-	265,467	-	738,724	1,123
100273390	Grant-Blackford Mental Health	CMHC	Psych	173,841	175,520	46,603	183
100269150	Greene County General Hospital	NSGO	Muni	1,989,208	1,614,467	157,318	428
100267930	Hancock Mem Hospital & Health Services	NSGO	Muni	3,788,843	3,075,072	755,384	2,035
100268250	Harrison County Hospital	NSGO	Muni	2,170,352	1,761,485	206,984	568
200266920	Healthsouth Rehab -Chow Ref 200484520****	Private	-	-	-	778	8
100270050	Hendricks Regional Health	NSGO	Muni	6,235,427	5,060,750	431,357	1,126
100269480	Henry County Memorial Hospital	NSGO	Muni	3,755,146	3,047,723	990,662	1,991
100268730	Howard Regional Health Systems	NSGO	Muni	5,382,323	4,368,360	1,159,672	2,678
200484520	Howard Regional Health System-West Campus	Private	-	-	-	78,551	249
100268810	Huntington Memorial Hospital	Private	Hist	2,339,424	2,356,238	306,283	893
200410370	Indiana Heart Hospital LLC, The	Private	-	53,005	-	646,773	212
200518770	Indiana Orthopaedic Hospital	Private	-	4,647	-	28,214	6
100269660	Jasper County Hospital	NSGO	Muni	2,766,193	2,245,077	192,545	796
100269610	Jay County Hospital	NSGO	Muni	1,731,079	1,404,964	342,068	716
100269800	Johnson Memorial Hospital	NSGO	Muni	3,270,453	2,654,340	479,231	1,628
100373250	Kindred Hospital - Indianapolis South	Private	-	69,789	-	24,498	2
100269210	King's Daughters' Hospital	Private	-	570,941	-	399,414	1,165
100270330	Kosciusko Community Hospital	Private	-	421,358	-	566,787	935
100269040	Lafayette Home Hospital	Private	1	6,728,661	8,471,569	1,124,191	1,169
100269110	LaPorte Hospital Inc.	Private	-	691,199	-	542,216	1,242
100268460	Lutheran Hospital of Indiana	Private	-	1,888,282	-	1,790,899	1,473
100270770	Madison Hospital Corporation	CMHC	Psych	68,786	69,450	50,516	25
100269870	Major Hospital	NSGO	Muni	4,219,805	3,424,847	389,329	1,555

Medicaid #	Hospital Name	Ownership*	DSH Class*	2007 Supplemental Payment	2009 Supplemental Payment	2009 HIP Claims Payment	2009 No. of HIP Claims Payments
100268010	Margaret Mary Community Hospital	Private	-	96,151	-	354,673	729
100269230	Marion General Hospital	Private	1/3	4,079,625	4,313,292	887,846	1,912
100269180	Memorial Hospital - Logansport	NSGO	Muni	2,677,971	2,173,475	400,100	1,188
100268610	Memorial Hospital and Health Care Center - Jasper	Private	-	680,430	-	558,906	1,613
100269840	Memorial Hospital of Seymour	NSGO	Muni	4,778,684	3,878,439	304,058	665
100269890	Memorial Hospital of South Bend, Inc.	Private	1	14,730,662	17,930,253	1,282,986	1,690
100268630	Methodist Hospitals Northlake Campus	Private	Hist	40,964,754	40,622,778	2,640,953	2,893
200484350	Michiana	Private	Psych	310,091	313,086	138,681	221
200836430	Monroe Hospital	Private	-	11,508	-	238,175	688
100269260	Morgan County Memorial Hospital	NSGO	Muni	2,928,971	2,377,189	740,412	2,614
200404950	Northeastern Center/Samara Unit	CMHC	Psych	146,632	148,049	69,601	32
100273510	Oaklawn Psychiatric Center	CMHC	Psych	63,893	64,510	49,039	180
200352690	Orange County Hospital	Private	2/3	753,426	942,081	299,246	511
200893400	Orthopaedic Hospital at Parkview North**	#N/A	#N/A	#N/A	#N/A	472,492	60
100273260	Otis R. Bowen Center	CMHC	Psych	128,113	129,351	80,678	549
100268480	Parkview Hospital, Inc.	Private	2/3	16,259,188	18,210,895	3,155,575	2,338
200524440	Parkview LaGrange Hospital	Private	-	49,652	-	221,559	313
200287080	Parkview Noble, A Community Hospital	Private	-	183,969	-	243,517	812
100269990	Perry County Memorial Hospital	NSGO	Muni	1,396,315	1,133,267	223,584	380
200916560	Physicians Medical Center**	#N/A	#N/A	#N/A	#N/A	31,841	10
100270110	Porter Memorial Hospital-Valparaiso	Private	-	20,858,600	-	1,040,869	1,764
200871590	Porter-Starke Services**	#N/A	#N/A	#N/A	#N/A	27,008	24
100270350	Pulaski Memorial Hospital	NSGO	Muni	978,880	794,471	379,229	593
100268680	Putnam County Hospital	NSGO	Muni	1,813,997	1,472,263	189,381	502
200097450	Rehabilitation Hosp Of Ft Wayne	Private	-	5,559	-	7,589	1
100274620	Rehabilitation Hospital Of Indiana	Private	-	104,053	-	147,045	57
100269700	Reid Hospital & Health Care Services	Private	-	1,430,652	-	1,125,889	2,284
200509740	Renaissance Specialty Hospital of Central Indiana	Private	-	13,246	-	44,158	9
200264930	Riverside Hospital Corporation***	#N/A	#N/A	#N/A	#N/A	8,291	4
100270300	Riverview Hospital	NSGO	Muni	4,953,719	4,020,500	847,560	1,425
100269820	Rush Memorial Hospital	NSGO	Muni	1,090,196	884,817	670,257	2,468
200816530	Saint Catherine Regional Hospital	Private	-	26,665	-	128,735	296

Medicaid #	Hospital Name	Ownership*	DSH Class*	2007 Supplemental Payment	2009 Supplemental Payment	2009 HIP Claims Payment	2009 No. of HIP Claims Payments
100268930	Scott County Memorial Hospital	NSGO	Muni	2,485,464	2,017,233	456,123	1,019
100368680	Southern Indiana Rehab Hosp-New Albany	Private	-	8,382	-	3,403	12
100273350	Southlake Community Mental Health Center, Inc.	Private	Psych	135,681	136,992	4,799	4
200324860	St. Anthony Medical Center of Crown Point	Private	-	1,380,430	-	665,230	984
100269360	St. Anthony Memorial Health Center	Private	Hist	9,474,241	9,431,524	778,762	1,139
100268310	St. Catherine Hospital	Private	Hist	14,319,107	13,185,370	2,079,762	4,251
200321440	St. Clare Medical Center	Private	-	48,413	-	149,072	439
200413490	St. Elizabeth Ann Seton Hosp Of Kokomo	Private	-	14,722	-	307,585	3
100269080	St. Elizabeth Medical Center	Private	-	404,148	-	1,172,853	1,326
100268070	St. Francis Hospital & Health Centers	Private	-	1,681,156	-	2,245,529	3,884
200409060	St. Johns Health System	Private	-	713,390	-	1,934,918	5,129
100269010	St. Joseph Hospital & Health Center	Private	-	303,321	-	957,195	3,025
100268500	St. Joseph Medical Center - Ft. Wayne	Private	1	6,941,757	9,455,177	862,353	1,552
100269940	St. Josephs Regional Medical Center South Bend	Private	-	2,512,581	-	729,390	788
100269590	St. Joseph's Regional Medical Center-Plymouth	Private	-	419,240	-	172,842	501
100268750	St. Margaret Mercy Health Care Center - North	Private	Hist	14,901,028	14,403,365	857,889	579
100466210	St. Margaret Mercy Health Care Center - South	Private	-	830,701	-	390,206	431
100268660	St. Mary's Medical Center	Private	-	1,252,286	-	1,233,561	1,816
100268410	St. Mary's Medical Center of Evansville	Private	-	3,160,514	-	1,708,311	2,165
200473800	St. Vincent Carmel Hospital Inc	Private	-	134,864	-	645,370	417
200348850	St. Vincent Clay Hospital, Inc.	Private	-	6,688	-	662,757	1,179
200272930	St. Vincent Frankfort Hospital, Inc.	Private	1	1,044,198	1,342,884	408,757	906
200398730	St. Vincent Heart Center Of Indiana, The	Private	-	704,708	-	506,362	75
100268950	St. Vincent Hospital & Health Care Center	Private	-	2,818,743	-	2,266,154	1,776
200260180	St. Vincent Jennings Community Hospital	Private	-	3,778	-	461,642	1,180
100268360	St. Vincent Mercy Hospital - Elwood	Private	-	9,076	-	610,547	1,450
200321460	St. Vincent Randolph Hospital, Inc.	Private	1/3	760,291	939,236	578,069	1,747
200392020	St. Vincent Seton Specialty Hospital	Private	-	27,360	-	496,505	12
100270250	St. Vincent Williamsport Hospital	Private	-	16,682	-	426,014	1,302
100225240	Starke Memorial Hospital	Private	1/3	$550,444	$524,588	$75,732	225
100269970	Sullivan County Community Hospital	NSGO	Muni	1,268,876	1,029,836	459,757	1,195
100270200	Terre Haute Regional Hospital	Private	-	341,138	-	1,030,099	841

Medicaid #	Hospital Name	Ownership*	DSH Class*	2007 Supplemental Payment	2009 Supplemental Payment	2009 HIP Claims Payment	2009 No. of HIP Claims Payments
200935230	The Heart Hospital at Deaconess Gateway LLC**	#N/A	#N/A	#N/A	#N/A	52,555	14
100270160	Tipton County Hospital	NSGO	Muni	915,563	371,541	400,666	473
100270020	Union Hospital -Terre Haute	Private	-	1,303,846	-	1,262,325	1,648
100273400	Valle Vista Health System***	#N/A	#N/A	#N/A	#N/A	411,160	227
100270780	Vencor Hospital - Indianapolis	Private	-	8,034	-	174,366	12
100270180	Wabash County Hospital	NSGO	Muni	1,099,035	891,990	84,674	168
100273160	Wabash Valley Hospital, Inc.	CMHC	Psych	162,099	163,664	15,681	164
100270700	Warrick Hospital Inc	Private	-	24,372	-	143,586	414
100269720	Washington County Memorial Hospital	NSGO	Muni	1,454,635	1,082,217	520,768	1,714
200431930	Wellstone Regional Hospital***	Private	Psych	-	-	126,669	49
100268170	West Central Community Hospital	Private	-	98,435	-	289,239	558
100270680	Westview Hospital	Private	-	18,804	-	135,153	368
100270480	White County Memorial Hospital	NSGO	Muni	1,456,079	1,181,772	178,957	589
100268830	Whitley County Memorial Hospital	Private	-	167,774	-	158,357	574
100268850	Wishard Memorial Hospital - HHC of Marion County	NSGO	Muni	132,382,871	135,041,865	3,423,116	11,414
100269130	Witham Memorial Hospital	NSGO	Muni	2,862,877	2,323,547	364,236	1,268
200327520	Women's Hospital, The	Private	2/3	1,571,223	1,758,083	83,492	66
100269760	Woodlawn Hospital	NSGO	Muni	1,312,208	1,065,004	382,105	475
	Total			**$663,259,551**	**$562,843,205**	**$97,727,490**	**167,421**

*Ownership and DSH Class can change over time. The Ownership and DSH Class in this table reflects status in 2009.
**These hospitals enrolled in Medicaid after the start of SFY 2008.
***These hospitals are psychiatric hospitals that were DSH-eligible from 2006 to 2009, but did not have uncompensated costs under their hospital specific limits.
****This hosptial stopped participating in Medicaid in 2004 and has had a change of ownership.

Data Source: FSSA Request No. 7627, HIP Hospital Expenditures, Run Date: 5/24/2010; OMPP.